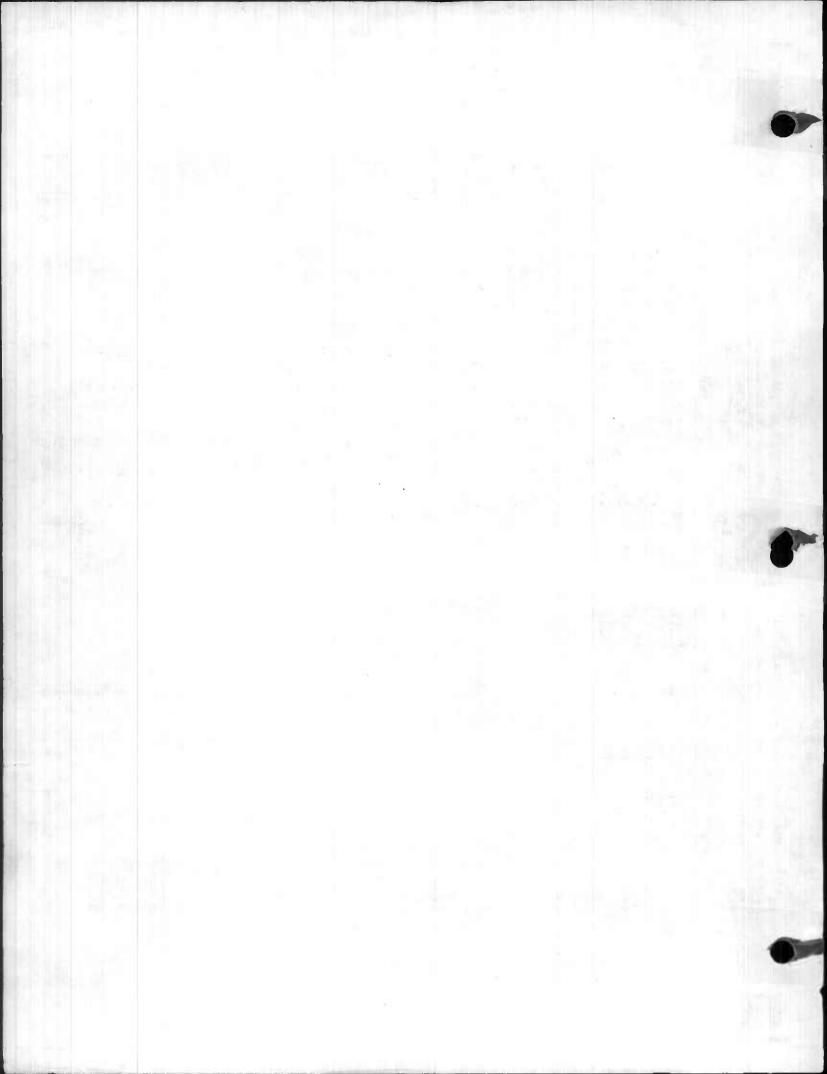
State of Maryland / Department of Health and Mental Hygiene 0 0 3 2 5 0 1

A STATE OF			Certi	ficate of	Death	R	eg. No.	J 32	.501		
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/Medical		FISHER				OCT			:30am		
Examiner	4a Facility Name (If not institution, giv BLAKEHURST HEA		NTER		4b. City, Town, or TOWSO	Location of Death	4c. County	of Death			
Funeral Director	216-46-3634	Sex 7. Age (In yr. □ M 2 1 F 88	N. A. S.	f Under 1 Year Months Days	H Under 24 Hrs Hours Min.		ݰ°° 12	9. Birthplece Country MARYI	(State or Foreign		
3	Usuet Residenca of Decedent  10a. Stete 10b. County	100.0	ity, Town or Locat	tion				104.1	Inside City Limits		
riedal tor	MD BALTIM		TOWSO						1 ☐ Yes 2 No		
or thems 23e or 25e-f show refers must be nothing at Puneral Director	10e. Street and Number 1055 WEST JOPF	A RD.		10f. Zip Code 21	204	1	0g. Citizen of V	izen of Whet Country?			
9	11. Meritel Stetus  1 □ Never Merried 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes:	4 6 70	s Decedent of I es, specify Cub Yes 2 No		Specify Yes or No- to Rican, etc.)		e - American Ir ck, White, etc.			
irked other than "natural; rite avent, the Medical Ex- TO Be Completed by	15. Decedent's E. (Specify only highest grade   (Specify only highest grade   Elementery/Secondary (0-12)   1 2	ducation ide completed) College (1-4or 5+)	(Give kin life. DO	at's Usual Occupation of of work done during most of working NOT use retired)  USEWIFE  HOMEMAK					у		
C	17. Fether's Name (First, Middle, Last,		HOMEMAKER  Name (First, Middle, Maiden Surname)								
To Be	GEORGE W. DOBBIN BEATRICE DUNDERDALE										
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	PENNY LEVERING(DAUGHTER) 14617 DOVER RD. REISTERSTOWN, MD. 21136.										
	20e. Method of Disposition  1 □ Buriel 2 ☑ Cremetion 3 □  4 □ Donetion 5 □ Other (Specif	Removal from Stete	cemetery, cremat	ory or other pla				City or Town,	MILLS, MI		
any Injury	21. Signature of Funeral Service Licensee  22. Name and Address of Fecility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212.										
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Te the Funeral Director: After property filled in by the fun Medical Certification	29e. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin end menner steted.	owledge, death oc ation and/or invest	curred at the ti	me, date and place opinion, deeth occu	e, end due to the coursed at the time, d	ause(s) and ma ate and placa,	anner es stated end due to the	f. ceuse(s)		
2 0	29b. Signature and title of certifier			29c. Licens				d (Month, Dey,	Year)		
2	100				783		oles 1	2)			
7/1	JOSEPH ADAMS	M.D. 6701 N	m 23a) (Type, Prin	LES ST	· EAST	PAVILIO	N TOWS	SON, MD	.21204.		
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	neture								

DHMH 16 Rev 6/95



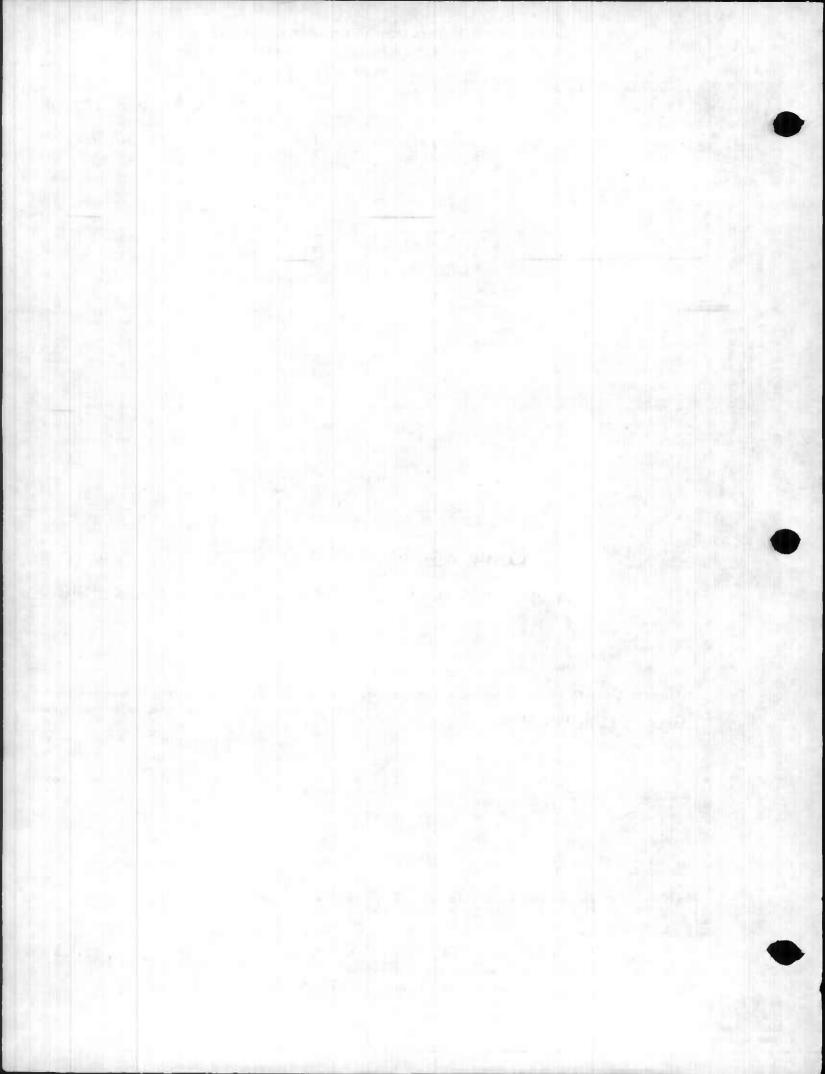
Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. Amended Item#19b perINFG788 10/16/2000 State of Maryland / Department of Health and Mental Hygiene 32502 Amended Item#10b,c,d,e,f perINFG788 10/16/2000 EW Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month COBER Yee **Physician** 12:27 A.M 2000 Margery Phillips Filler /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner KOSEDALE DALTIMORE FRANKLIN SQUARE HOSPITAL CENTER If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** 1 □ M 2 N F Months Deys Hours Yrs. 212-22-8970 June 29, 1909 Wales England Director Usual Residence of Decedent the Marylend 10d. inside City Limits 10a State 10b. County 10c. City. Town or Location 28a-f show the Medical Examiner must be notified at MD Baltimore Yes 2 No Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7515 Bay Front RD 21219 Herra 23a or 7501 Iroquois Avenue 2119 Funeral USA 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American indien. Bleck, White, etc. 1 Never Married 2 Married Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: white Specify: þ 3 ₩idowed 4 Divorcad Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) then. Elementery/Secondery (0-12) College (1-4or 5+) +5 concert organist musica1 Il Hygie 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 2 should be fi and Mental F is marked off Issac Griffith Hooper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Pages 1 and 2 s ment of Heelth an If item 27 i Marion Syzmanski/daughter 7501 Iroquois Ave Baltimore, Md 21219 20e Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important if Imy injury or page. 4 X Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
11AM 1232 Midvalley Drive 21. Signature of Europa Sprice Licensee Rohald S. Wade, Director Jessup, PA 18434 Mell mull Ph.11. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, make, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician Immediete Ceuse (Finel diseese or condition resulting in death) /Medical Congestive Heart Examiner Examiner Hypertensive Atherosclerotic Curdiovascular Disease Physician: The lew requires that the deeth certificate be asscuted Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Box 68760. Completed by Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Fibrillation 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? pege 2 1 Yes 1 Yes 2 No 2 No director. 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No Certification: To this 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of s after death.
I Director: After od in by the funer After Division 1 Neture 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 🗹 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completaly 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 39666C w 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 9000 FRANKLIN SQUARE BALTIMORE MD 21237 ROBERT DART, DRIVE 32. Registrer's Signature 31. Dete filed (Month, Dey, Year) State DCT 1 6 2000

DHMH 16 Rev 6/95

Registrar

MARJORIE

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Robert

00-5758-510 crn Andre Herbert Gilliam	Please Type or Print in Black I State of Maryland / De	ndelible lnk. Assure Apartment of Health and			9 9	0.0	
amend item 23a,27,28a,t	o,c,d,e,f per me G788 10/19/00 yf C	ertificate of Death	Re	g. No.	UU	3251	04
Physician	me (First, Middle, Last)		2. Deta of Deat Month	h Dey	Yeer	3. Time of i	
/Medical Andre H	erbert Gilliam		October	09,	2000	10:04	A.M.
Examiner 4a Facility Neme	(If not institution, give street and number)	4b. City, Town, or	Location of Death	4c. C	ounty of Deeth	1	
1110	- 7 7 7 8						

Directo

Funeral

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Completed

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**Funeral** 

Director with the Manylend 28a-f show item 27 le marked other then "natural", or itema 23a or 28a-f ahor other treumatic event, the Madical Examiner must be notified at el Hygiene.

Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mentel Hygiene. permit. Pages 1 end 2: Department of Heelth ar Important: If frem 27 le any Injury or other treuence.

Baltimore, Maryland 21215-0020

Physician/Medical Examine sicien end burial-transit The law requires that the deeth certificate be execu P.O. Box 68760, ettending physicien for use as the burie as the US8 ate has been signed by the e page 2 should be detached it Division of Vital Records, by Medical Certification: To Be Completed After this

Physician /Medical **Examiner** To the Hospital or Attending Physician: filled in by the funeral director, after death. Within 24 hours a sempletely.

4413 Old York Road Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Deys Min XXM 2 F Yrs. 218-60-2563 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 21212 USA 4409 Old York Rd 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuben, Mexican, Puarto Rican, etc.) Race - American Indien, Bleck, Whita, etc. Yes 2 No if Yes, Give Yeer or Detes: Army 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify. Specify: Black 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Laborer Construction 11\_th 17. Father's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Irene Holmes Overton Gilliam 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Intormant's Name/Relationship (Type, Print) Marva Gilliam Gaffney (Ex-Wife) 1604 Sherwood Rd. Baltimore, Maryland 21239 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Buriel 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 10/14/00 Landsdowne, Maryland Zion Cemetery 22. Name end Address of Fecility Caple Funeral Service Balto., Md. 21215 5502 Winner Ave. 23a. Part . Finer the disease of complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock or heart failure. Call only one causa on each line. Immediata Cause (Finel disaasa or condition resulting in deeth) MULTIPLE STAB AND CUTTING WOUNDS Due to (or es a consequence ot) Sequentially list conditions, if eny, leading to immadiete ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Dua to (or as e consequence ot): Dua to (or as a consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings eveileble prior to completion of causa of death? 24a. Wes en eutopsy performed?

25. Wes cese reterred to medical examiner? 26. Piece of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) at Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1⊠ Yes 2□ No 28d. Describe how injury occurred Subject stabbed

28a. Date of injury (Month, Day Year) 28b. Time ot 28c. Injury et Work? A fourid: М 9:55

and cut 1 ☐ Yes 2 No 10/9/00 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, State) 4408 Old York Rd., Baltimore, Md. found in yard 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the ceusa(s) end menner steted.

29b. Signeture end title of certifie

5 Pending investigation

6 Could not be determined

27. Menner of Deeth

1 Neturel

2 Accident

3 Suicide

29e. Certifier

4 CHomicide

31. Data filed (Month, Day, Year)

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) October 10, 2000

1 Yes 2 No

10d. Inside City Limits

Approximete Interval Between Onsat and Death

Ves 2□ No

Yes 2 No

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print)

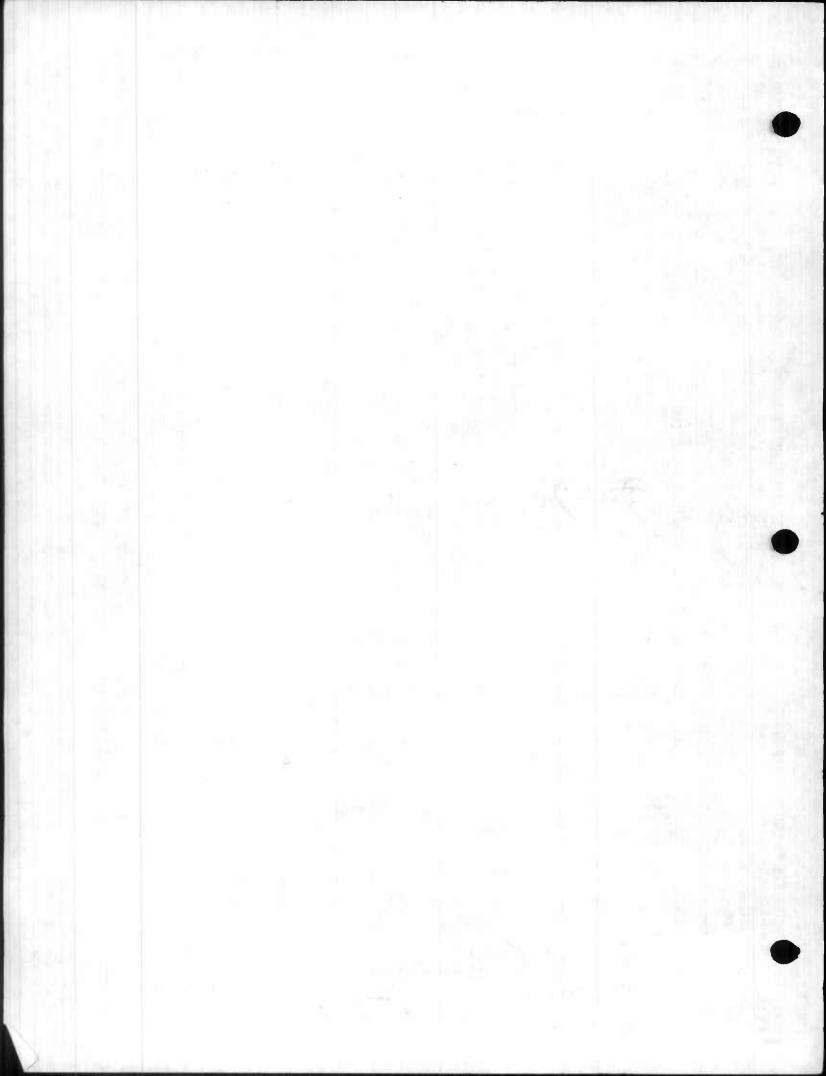
HEDDORE

111 Penn Street, Baltimore, Maryland 21201

State Registrar

OCT 1 6 2000

32. Registrer's Signeture

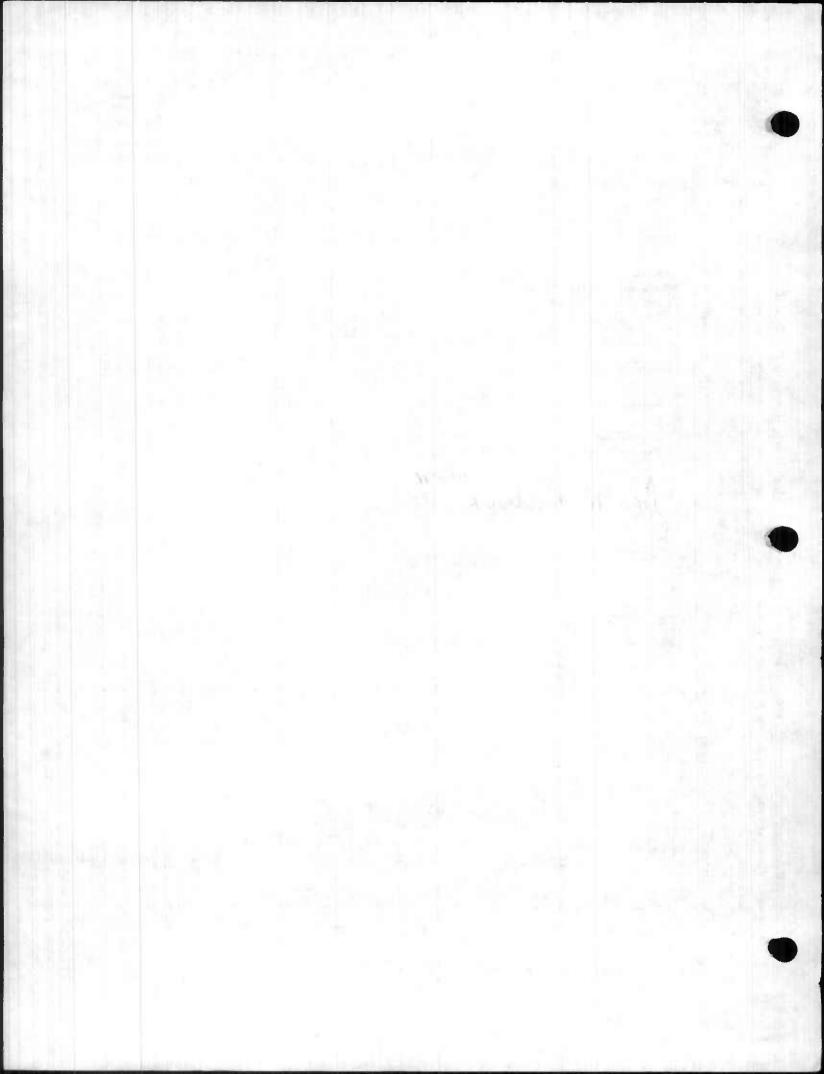


State of Maryland / Department of Health and Mental Hygiene 00 32505

				Certifica	ate of	Death			Reg. No.		74000	,
	1. Decedent'a Name (First, Middle, La	est)						2. Date of Dee	oth Dey	Year	3. Time of De	ath
Physician /Medical	Carris Lee Goins	5						October			4:10 ar	n
Examiner	4e Facility Name (If not institution, gir	ve street end numb	er)			4b. City, To	wn, or L	ocation of Deeth				
	Riverview Nursi	ng Center				Es	sex		Bal	timor	re	
Funeral			Age (In yrs. last birt	Month	der 1 Yeer		24 Hrs. Min.	8. Date of Birti (Month, De)	h v, Year)	9. Birthp	lace (Stete or Fo	<i>preig</i> n
Director	244 03 4925	1 🔀 M 2 🗆 F	92	rrs.				Oct. 10	, 1908	South	Caroli	na
8 8	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						1	0d. Inside City L	imits
aho ad at	Maryland Baltimon	re		dle Ri	vor						1 ☐ Yes 26	
or ster or be notified	10e. Street and Number		1110		Zip Code				10g. Citizen of V	What Cour	ntry?	-
Die Die	17 Honeysuckle La	ano		101.	212	220			US		Acy I	
flor death v flore 23s siner must	11. Marital Status	12. Wes Decede	ent Ever in U.S.	13. Was De			igin? (Sp	pecify Yes or No-		e - Americ	an Indien,	
her of the dine of the control of th	1 Never Married 2 Married	Armed Force	es?	11 Yes, s	pecify Cub	an, Mexicar	n, Puèrto	pecify Yes or No- Rican, etc.)	Blac	k, White,	etc.	
by by		If Yes, Give Yeer or Date		1 ☐ Yes	2 M No	Specify:			Specify	· Whi	.te	
2 ho	15. Decedent's E	ducetion	16a.	Decedent's U	sual Occu	pation	at ad award	utaa	16b. Kind of Bu	usiness/Inc	dustry	
ygiene.  ygiene.  v. the Medical.  Completed	(Specify only highest gr	College (1-4	or 5+)	life. DO NO	d of work done during most of working NOT use retired)				State Health Depart			noni
Manual To	6			Cour	ier						Deparu	HEITI
tal the double avenue	17. Father's Name (First, Middle, Las				18. Mother's Name (First, Middle, Meiden Sumeme) Nannie Alice Mathews					10)		
Ment Ment Ment Ment Ment Ment Ment Ment	John Tielman Goi	ns										
2 and a send a s	19a. Informant's Name/Relationship							ral Route Numbe			Code)	
and salth m 27 her th	Dale S. Goins (So	on)				n Ra.	Bal	Ltimore,			Olate	
H Ite	20e. Method of Disposition 1XI Burial 2 □ Cremetion 3 [	Removel from St	919	y, cremetory o	or other ple		1	1//	20c. Location -			
Family dury	4 □ Donation 5 □ Other (Special			s Of F			1	10/1400	Bal	timor	re, Md.	
emili epan ny in	21. Signature of Funeral Service Lice	nsee /	1 MO1091			ess of Facili		al Home	ת כו			
20160	John W. K	wikous	k	1407	old	Easte	rn A	Avenue E	ssex. M	d. 21	221	
	23a Party Enter the disease, or con	policetions that cau	ised the deeth. Do not hime.	not enter the n	node of dy	ing, auch as	cerdiac	or respiretory er	rest,		Approximete Interval Between	en
Physician	V	0		1-		1 -1				1	Onset and Dea	th
/Medical Examiner	Immediate Cause (Final disease or condition	, Ke	3 Dura	1004	-	tail	M	e		1	lears	
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be executed sician and bunish-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury		Due to (or as a c	consequence	of):	5				1	me we	ek
	cause. Enter Underlying Ceuse (Disease or injury that initiated events	c	5 (		0							
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requires that seen signed b hould be dete									an autopsy	24b. W	ere autopsy find	ings
law require es been si 2 should npieted	S SCHOOL STATE							peno	meur	CO	empletion of cause death?	50
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certificate rector, pag	25. Was cese referred to medicel					26 Pian	e of Dea	ith (Check only o			2900	
	examiner?	Hospital:	patient 2 ER/Ou	tostient 3	DOA OI	thor		ome 5 Resid		er (Specia	fv)	
2 2 2	27. Manner of Death	28e. Dete of (Month,		ime of	28c. Inju				now injury occur			
Attending In deeth.  octor: After by the funer iffication	1 ☑ Netural 5 ☐ Pending 2 ☐ Accident investigation		Day rear) II	njury M		Yes 2	No					
or Attendiate death Director: A in by the fertificati	3 Suicide 6 Could not 1 determined	288. Place 0	Injury - At home, la	rm, street, fac	tory, office			281. Location (S City or Tox		ber or Rur	el Route Number	r,
al or Attending P rs after deeth. al Director: After t led in by the funers Certification:		building	, oto. (openly)					2, 0. 101				
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within To the comple	29b. Signeture end title of certifier	TAISA	masin	~	29c. Licen	se number	61		29d. Date signe	d (Month		2
1	Joursh	( rup			U	200	01	0	cloker.	13	2000	
3	30. Name and address of person who	completed cause	ol death (Item 23a) (	Type, Print)	5100	eesh	-61	RIPUR	ANGI	V/		
	3601 Web Kal	ec 1511	1a, 120	ellia	nor	1 8	d	-216	239	1		
State	31. Date filed (Month, Dey, Year)		Istrar's Signature	1/2	1		00					
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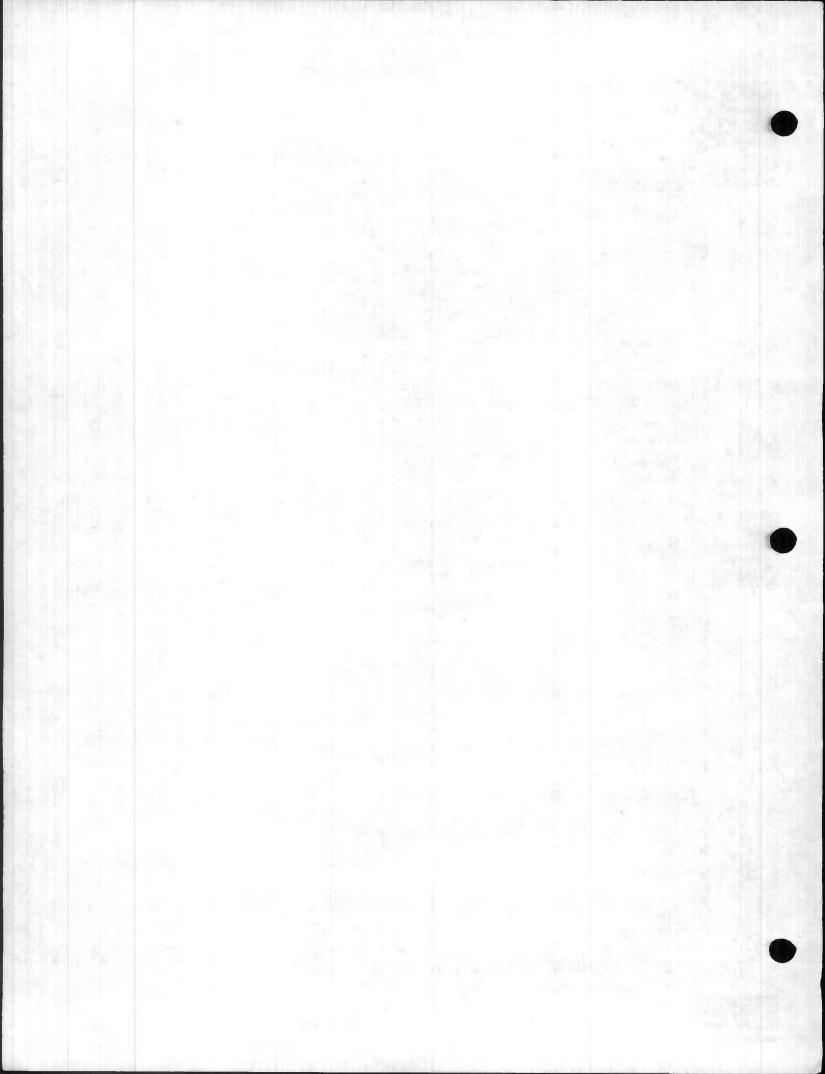


State of Maryland / Department of Health and Mental Hygiene 32506 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month Dav Voer **Physician** 12th LENORA E. GREEN OCTOBER 2000 09:08 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LEVINDALE HEBREW HOME BALTIMORE N/A If Undar 1 Yaar | If Undar 24 Hrs. Birthplaca (Stata or Foraign Country) 5. Social Security Number 6. Sax 7. Aga (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** 1 M 2 K F Months Days Hours Yrs 219-32-3259 79 SEP.25, Director N.C. Usual Rasidanca of Decedant r 28a-f show 10a Stata 10h County 10c. City. Town or Location 10d. Insida City Limits Yas 2 No Director MD N/A BALTIMORE 10a. Street and Number 10f. Zip Code 10g. Citizan of What Country? re 23a or 3211 CLARKS LANE #314 21215 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married ò Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: WHITE by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Pagas 1 and 2 should be nant of Haalth and Mental 7 is marked traumatic a MORRIS KIRSCH SADIE CARMEL 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Haalth a: If Item 27 is 2415 BRAMBLETON ROAD - BALTIMORE, MD 21209 MICHAEL GREEN / SON 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or poss. 10/13/00 BALTIMORE, MD ANSHE EMUNAH AITZ CHAIM 21. Signatura of Minaral Sarvice Licansee 22. Nama and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 unter 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Onsat and Death Physician Immediata Causa (Final disaesa or condition rasulting in daath) /Medical a CORDNARY ARTERY DISEASE 2 YEARS **Examiner** Dua to (or as a consequence of): Examine IYEAR DEMENTIA that the death certificate be executed Sequantially tist conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Box 68760. Physician/Medical Dua to (or as a consaguanca of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown 6 Completed by Division of Vital Records. 24b. Were autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? page 2 has 1 Yas 2 No 1 Yas 2 No or Attending Physician: 25. Was casa refarred to medical axaminar? Be 26. Placa of Deeth (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA To Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No this 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 27. Mannar of Death 28b. Tima of 1 Natural 5 Panding 1 | Yas 2 | No death. Invastigation 2 Accident aftar death 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 6 Could not be detarmined 3 Sulcida 28a. Pieca of Injury - At home, farm, straat, factory, offica building, atc. (Specify) 2 4 Homicida To the Hospital of within 24 hours a To the Funeral C completaly filled 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the causa(s) and menner es stated.
2 Medicai Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the causa(s) and manner stated. edicai (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar October 12th 2000 D 054739 Donna Donna m Cuersley m.D 30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print) Avenue, Baltimore Maryland 21215 w. Belvedere 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

DHMH 16 Bey 6/95

Registrar

**ORIGINAL** 



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

				Certi	iricate	UI	Dealli			Re	g. No.			
/sician ledical		Evans Gain	es						2. Dete of Month OCTO	BER			3. Time of Deeth	
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eral ctor	5. Social Security Number 6. S	ex 7. Age (/	In yrs. last bir 76	thday) Yrs.	If Under Months	Year Deys	If Under Hours	24 Hrs. Min.	8. Date of (Month)	Birth Day, 24	1924	9. Birth	plece (State or Fore htry) yland	
w	Usuel Residence of Decedent  10a. Stete 10b. County		0c. City, Tow	n or Loca	ation							1	Od. Inside City LIm	
ctor	Md. Baltimo	re	Ow	ings	Mil	ls							1 ☐ Yes 2 📉	
Director	10e. Street and Number	D.a			10f. Zip	Code 211	200			10	g. Citizen of V	S.A.		
Funeral	43 Wengate	12. Wes Decedent Eve	er In U.S.	13. W	Wes Decedent of Hispenic Origin? (Speci if Yes, specify Cuban, Mexican, Puerto Ri				ecify Yes o				can Indian,	
b A	1 Never Merried 2 Merried	Armed Forces?  1 Mes 2 No If Yes, Give Yeer or Detes:			If Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No Specify:				Rican, etc.)			Black, White, etc.		
eted	15. Decedent's Ed (Specify only highest gra	ducation de com <i>pleted)</i>	16e	(Give ki	nt's Usua ind of wor	done	during mos	at of work	16b. Kind of Busin			siness/in	dustry	
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To Be Co	17. Fether's Neme (First, Middle, Last) George Gaines					er's Nem	ne (First, Middle, Meiden Surname) Gordon							
See .	19e. Informant's Neme/Reletionship ( Bessie Gaines =	**									City or Town,		Code)	
ry or other	20a. Method of Disposition  1	Domestal from Chate		ry, crema	atory or of	her ple		Oct	Dete . 17,		Oc. Location -			
any Injury or off	21. Signature of Fusieral Service Licenses  22. Name and Address of Facility  Evergreen Mem. Gardens Oct. 17, 2000 Finks  22. Name and Address of Facility  Eckhardt Funeral Chapel  11605 Reisterstown Rd., Owings M								(illa	s. Md. 21				
ian ical ner Examiner	Immediate Cause (Final disease or condition resulting in death)  PNEUMONIA  Due to (or es e consequenca of):  MULTIPLE MYELOMA  TWO YEAR  Due to (or es e consequenca of):													
se as the bur	cause. Enter Undertying Cause (Disease or injury that initieted events resulting in death) Lest	c	e to (or es e	conseque	ence of):									
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De ector	25. Wes case referred to medical examiner?	Hospitel:				Oth	hor:		th (Check o					
	1 Yes 2 No  27. Menner of Deeth  1 Neturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Y	28b.	Time of Injury		Bc. Injui	4UN				nce 6 □Oth w injury occur		ify)	
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	PATRICK BU		th (Item 23e)		Print) SINA	1 +	HOSP	1774	LOF		BALTI	MOR	Z	
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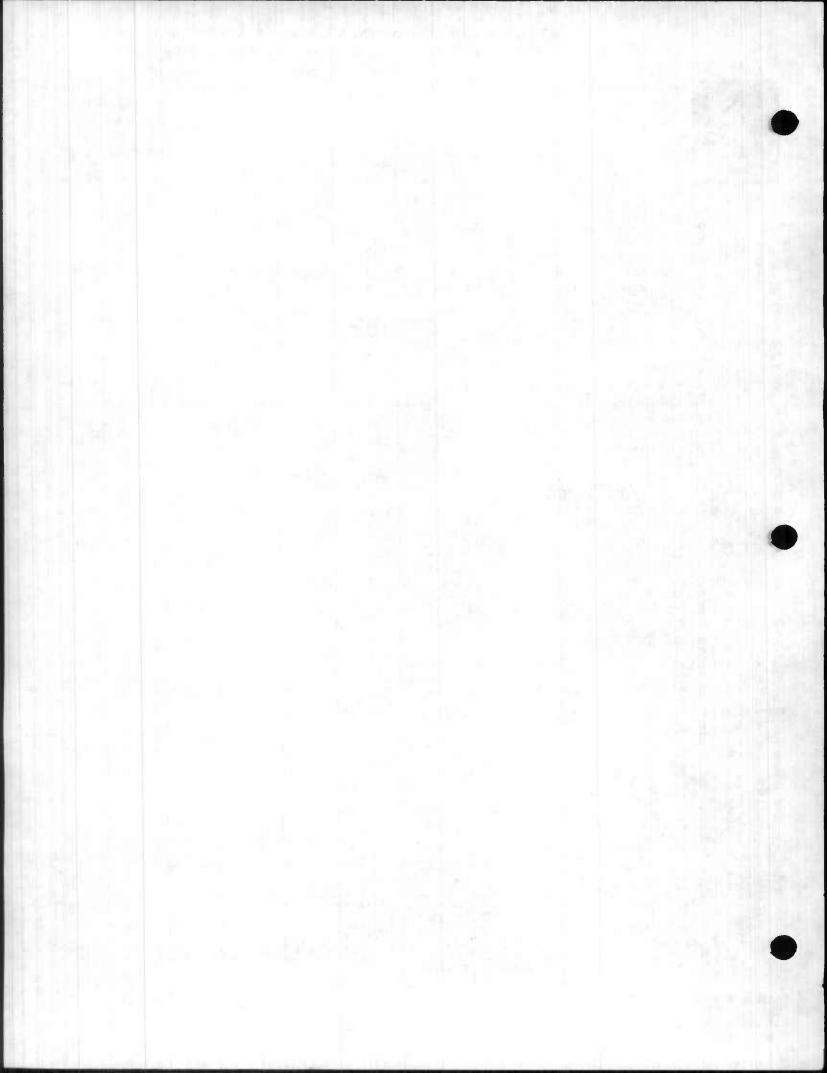
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State of Maryland / Department of Health and Mental Hygiene

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/Medical Examiner	4a Facility	Name (If not institu	ution, give	a street and	d number)					4b. City, To		cation of Dee		. County o			
LAdimine	Unio	n Memoria	1 Ho	spita	1				Baltimore N/A								
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or hems miner.m	1 D No	over Merried 2 N	Merried		d Forces?		If Yas, specify Cuben, Maxican, Puerto Rican, et					Hican, etc.)					
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	5)	(Specify only hig				-	(Give	kind of wi	ork dona Ise retire	<i>during</i> mos d)	t of worki	ing	g				
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marked out	Unkno	own							Unknown								
To To		ment's Neme/Reletion	ingship /7	Tyne Print	)	1	9h Mailin	ng Addres	s (Street			al Route Num	ber City o	or Town S	State Zio	Code)	
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em 27 other tr		od of Disposition		(550		20b. Place	of Dispo	sition (Na	me of		Dall	Dete		ocation - C		wn. State	
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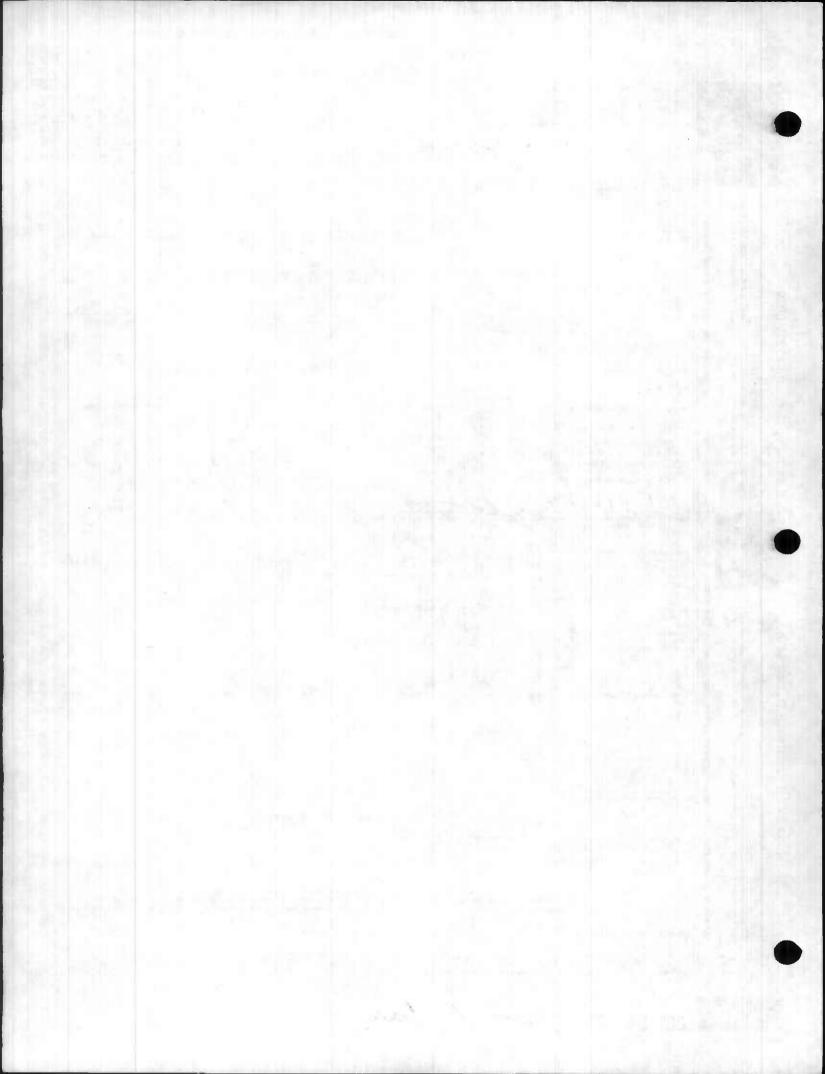


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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hysician	Decedent's Name (First, Middla, Las     MARIE D. HOW					2. Data of De Month	Day Day	Year 245			
/Medical	4a Facility Nama (If not institution, giva				4b. City, Town,	or Location of Deat	h 4c. County	of Death			
xaminer	C 11 C	RE Hospital	CENTER	0	ROSE BA	LE		Timore			
ineral ector	5. Social Security Number 6. Security Number 11.	9X 7. Aga (In y.	rs. last birthday) Yrs.	If Undar 1 Ye Months Day		rs. 8. Data of Bi	th ax. Year)	Birthplace (Stata or Foraig Country)     DELAWARE			
	Usual Residence of Decedent										
9 .	10a. State 10b. County	10c.	City, Town or Lo					10d. Inside City Limit You Yes 2 N			
ecto	MD N/A		BALTIMO	1			40- 08				
rai Director	10e. Street and Number 1234 FRAILEY WAY	7		10f. Zip Cod	21205	= 47 = 7.	10g. Citizen of What Country?  USA				
eral	12.34 FRAILEI WAI	12. Was Decedent Ever in	US 13 V	Vas Decedent o			o- 14. Rac	e - American Indian,			
by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Yes, specify C	of Hispanic Origin? Luban, Mexican, Pu No Specify:	èrto Rican, etc.)	Specify	ck, White, etc.  WHITE			
Be Completed	15. Decedent's Edi (Specify only highast grad	ucetion	16a. Deced	16a. Decedent's Usual Occupation (Giva kind of work dona during most of wor			16b. Kind of Bu	usiness/Industry			
nple	Elementary/Secondary (0-12)	College (1-4or 5+)	lifa. L	OO NOT usa rai	rired)	VOIKING	17/12	OF BY 1100 CT			
Co	12	0	HO	OMEMAKE				IN HOME			
B	17. Fathar's Nama (First, Middla, Last)					lame (First, Middle	18)				
10	WALTER DYER	Delay.	405 14-35	- A dal (CA-	EMMA	TARR	one City or Tour	State 7in Code)			
DI 20a.	19a. Informant's Name/Relationship (7 DIANE I. BLEVINS /			HEMLOC	eet and Number or K ROAD I	EDGEWOOD,					
	20a. Method of Disposition  1 Sturial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Nama of cematary, cramatory or other place)  GARDENS OF FAITH  10/16/00 BALTIMORE,										
	21. Signature of Funeral Service Littlesee  22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE BALTIMORE MD 21237										
	Part Enter the classes, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line.  Approximate Intervet Between										
an	shock, or heart fallure. List only of	one cause on each line.			,			Onset and Death			
ai	Immediate Cause (Final	(1	. )		- 75: 0-			10.0000			
ner	disease or condition resulting in death)	a. Chronic Ot	o (or as a conseq		y Disea	<u>5e</u>		10 gears			
ne ne											
T S	Sequentially list conditions,	Due to	o (or as a conseq	uence of):	13						
Û	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury c.										
Medical Examiner	that initiated avents resulting in death) Last		o (or as a consequent	uence of):							
should be detached for use es leted by Physician/Me	Part II. Other significant conditions co	d	requiting in the un	dodvina sausa	gives in Bad I	23h Die	I tobacco use co	ntribute to the cause of deat			
Physician	Partii. Other aignificant conditions co	minibuting to death but not	resulting in the di	idenying cause	given ar raiti.		Yes 2 No	3 Probably 4 Unkno			
by F						_		1			
Completed by						24a. Wa per	s an autopsy formed?	24b. Were autopsy findings available prior to			
npie							/	completion of cause of death?			
Co						12	Yes 2□ No	1 ☐ Yes 2 ☐ No			
e e	25. Was cese referred to medicel examiner?	Magnital.				Deeth (Check only	ona)				
	1 Van OCTAIN		ER/Outpatien	1 3LI DOA		g Home 5 Res	how injury occur				
-	1 Yes 2 No		28b. Time of	200. 1	njury at Work?	280. Describe	now injury occur	160			
ion: To	27. Manner of Death 1 ○Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	) Injury	ation M 1 Yes 2 No							
	27. Manner of Death	28e. Place of Injury - A	t home, farm, str	М	1 ☐ Yes 2 ☐ No	28f. Location City or To	(Streat and Numb own, Stata)	ber or Rural Routa Number,			
	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only 2 Medical Exam	28e. Place of Injury - A building, etc. (Specials: To the best of my Iner; On the basis of exam	t home, farm, str	M eet, factory, offi	1 ☐ Yes 2 ☐ No ce	City or To	own, Stata) cause(s) end m	anner as stated.			
edical Certification:	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  27. Manner of Death 5 Pending investigation 6 Could not be determined	28e. Place of Injury - A building, etc. (Special Control of the best of my leading)	t home, farm, str	M eet, factory, offi	1 Yes 2 No	City or To	own, Stata)  cause(s) end many date and place,	anner as stated. and due to the cause(s)			
Medical Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only 2 Medical Exam	28e. Place of Injury - A building, etc. (Specials: To the best of my Iner; On the basis of exam	t home, farm, str	M eet, factory, offi	Yes 2 No	ace, and due to the	e cause(s) end many date and place,	anner as stated. and due to the cause(s) and (Month, Day, Year)			
edicai Certification: 1	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier  Marco	28e. Place of Injury - A building, etc. (Spot pullation) and the basis of example and manner stated.	at home, farm, str ecify) knowledge, death ination and/or inv	M eet, factory, offi	Yes 2 No	ace, and due to the	e cause(s) end many date and place,	anner as stated. and due to the cause(s) and (Month, Day, Year)			
delety filled in by the funera	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier  Marco	28e. Place of Injury - A building, etc. (Specials: To the best of my Iner; On the basis of exam	at home, farm, str ecify) knowledge, death ination and/or inv	M eet, factory, offi	1 Yes 2 No	ace, and due to the	e cause(s) end many date and place,	anner as stated. and due to the cause(s) ad (Month, Day, Year)			



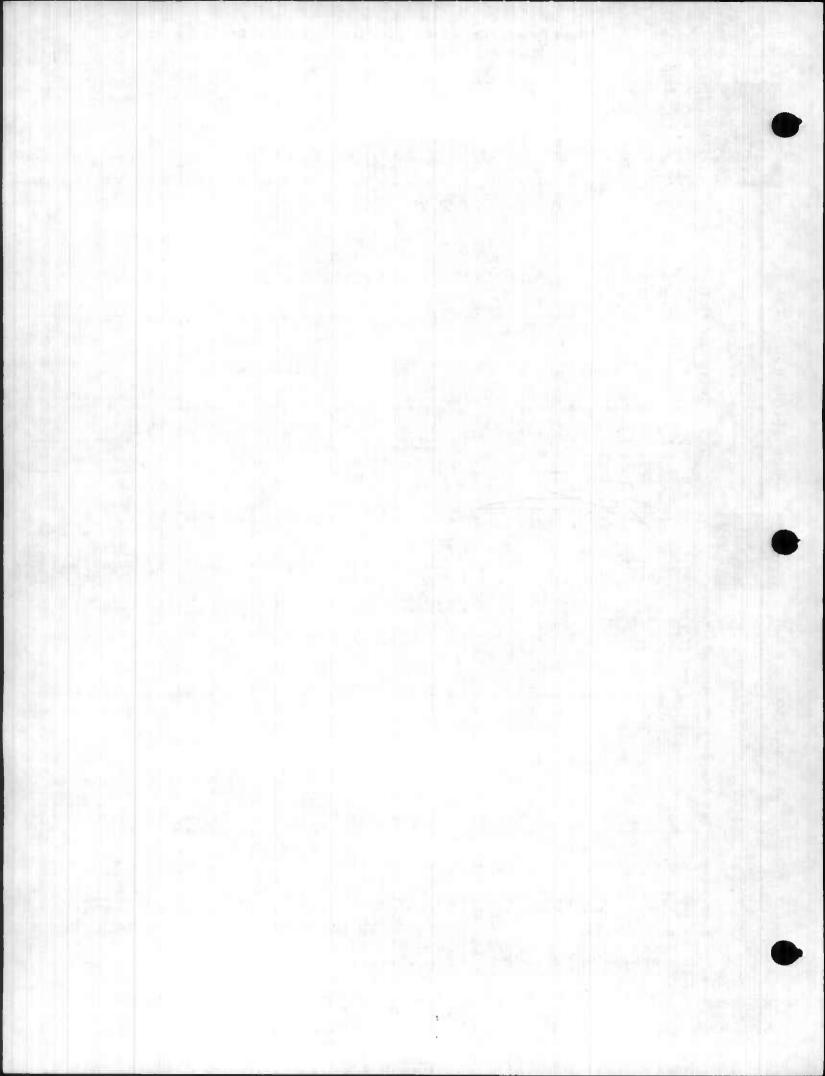
00-5844-005 GEORGE WILLIAM

**DHMH 16 Rev 6/95** 

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32510

AUSER		Otate of Wi	aryland / L	Certifica		Death	wientai riy	Reg. No.	0 32	2010	
Dhysisian	1. Decedent's Name (First, Middle, La						2. Defe of De Month	ath Day	Year 3.1	Time of Death	
Physician /Medical	George William	Hauser					OCTOBE	R 12, 20		:11 PM	
Examiner	4a Facility Name (If not institution, give					4b. City, Town, or	Location of Deat				
	FRANKLIN SQUARE			· · · · · · · · · · · · · · · · · · ·	1	Rossville	2		IMORE		
Funeral Director	5. Social Security Number 217–14–6150	ex ⊅M 2□F	e (In yrs. last bii 76	Yrs. Month		Hours Min.	8. Date of Bir (Month, De Nov. 2	th, Year) 2,1923	9. Birthplace ( Country) Mary Lar	State or Foreign	
death with the Maryland ms 23a or 28a-f show matter be notified at neral Director	10a. State 10b. County	e	10c. City, Tow Essex							side City Limits	
or 28a	10e. Street and Number			10f. 2	ip Code			10g. Citizen of	What Country?		
th with	7 Valley Arbor Co	urt. Apt.	'C"		1221		F 13/9	U.S.A.			
2 2 2 5	11. Marifal Status  1 Never Married 2 Merried	12. Was Decedent Armed Forces? 112 Yes 2 1 If Yes, Give	Ever in U,S. 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu							dian,	
ours a		Yeer or Detes:	AAAATT	1 LI Yes	200 NO	Specify:		Specif	A: MJ	nite	
Baltimore, Maryland 21215-0020  semit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Merial Hygiene. Theorem: If fem 27 is marked other than natural; or the my injury or other traumatic event, the Medical Examinate.  To Be Completed by Ful	15. Decedent's E (Specify only highest gra Elamantary/Secondary (0-12)	lucation de completed) College (1-4or t	5+)		vork done usa retire	pation during most of word)	rking		usiness/Industry		
filed with Hygiene. wher then end, the Men.	10 Bus Driver 17. Fathar's Name (First, Middle, Last) 18. Mother's						ma /Circl Middle		portation	OI1	
re, Maryland 212 s 1 and 2 should be filed with f Health and Merial Hygiene. fem 27 is marked other than other traumatic event, the M	17. Fathar's Name (First, Middle, Last)  George Hauser  18. Mother's Name (First, Middle, Maidan Sum.  Blanche Wilson							na <i>j</i>			
E should be end Mental is marked o	19a. Informant's Name/Relationship (	Type Print)	195	Mailing Addra	ss (Street	end Number or Ru			State. Zin Code	.)	
Ma dd 2 s iff en iff en	George W. Hauser					ue, Esse					
Health Health other tr	20a. Method of Disposition	DI. (SOII	20b. Place o	Disposition (A	eme of		Date		- City or Town, S	tate	
TO Pages	1⊠ Burial 2 □ Cremation 3 □ 4 □ Donetion 5 □ Other (Specif		Oak La	ry, crematory o	neter		0/16/200	00 Balti	more. M	arvland	
Baltimore, M pemir. Pages 1 and 2 Department of Health important: if item 27 is any injury or other tra once.	21. Signature of Funancial Sept ce Licer		Oak De			4 1					
Depa Depa sany le	16/2	Bruzdziński Funeral Home, P.A.									
	1407 Old Eastern Avenue, Essex, Maryland, 2122  23a Part Fahr I e disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, approximate Interval Between										
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Atheros	Dua to (or as a	consequance o	():	scular	Disca.	se			
requires that the death certificate be assouted seen signed by the attending physician and thould be deteched for use as the burial-transit eted by Physician/Medical Examiner	Sequentially list conditions, if any, laading to immediate causa. Entar Underfying Cause (Disaase or injury that initiated events rasulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):										
P.O. BOX ( nat the death certified by the attending letteched for use a Physician/M.		1									
O. E	Part II. Other significant conditions of	ontributing to death b	ut not resulting in	n the underlying	cause giv	ven in Part I.	23b. Dld	cause of death?			
Is, P.O. Box as that the death cer igned by the attending be detached for use by Physician/N.			L13399	368			10	Yes 2 No	3 Probably	4 Unknown	
2 2 8							24a. Was	an eutopsy ormed?	aveilable	ion of cause	
F 0 0							1图	Yes 2□No	1 X Yes	2 No	
of Vital In Physician: The this certificate ral director, page	25. Was case referred to medical axaminar?						ath (Check only	ona)			
Of Vita Physician: this cartific ral director.	Yes 2□ No	Hospital: 1 Inpatie			DOA		lome 5□Ras	dence 6 Ott	ner (Specify)	11400	
After fune	27. Mannar of Death  1 Natural 5 Panding 2 Accident investigation			Time of Injury M	28c. Injui Wo 1 🗆	y at rk? Yes 2 □ No	28d. Dascribe	how injury occur	rred		
Division  Division  al or Attended.  In Director: After ed in by the fune Certification	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inj building, at	ury - At home, fa c. <i>(Specify)</i>	irm, street, fact	ory, office		28f. Location ( City or To		ber or Rural Rou	te Number,	
Division c To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying Ph	ysicien: To the best niner: On the basis of and manner sta	axamination an	a, daath occurre d/or investigation	d at the ti	ma, date and place ppinion, death occu	e, and dua to tha urred at the tima,	causa(s) and m data and place,	anner as stated. and dua to the o	causa(s)	
To the comple	29b. Signature and fittle of certifier	1	,	2	9c. Licens	icense number 29d. Date signed (Month, Dey, Year)				Year)	
	AtyM A  30. Name and address of person who	complated cause of d	eath (Item 23a)	(Type, Print)	OCMI	Ξ		OCTOBE	R 13, 20	000	
5.1		adentz							to the second		
State Registrar	31. Date filed (Month, Day, Year)	000 32. Ringistr	ar's Signature	Penn	Stree	et, Balti	more, M	aryland	21201		

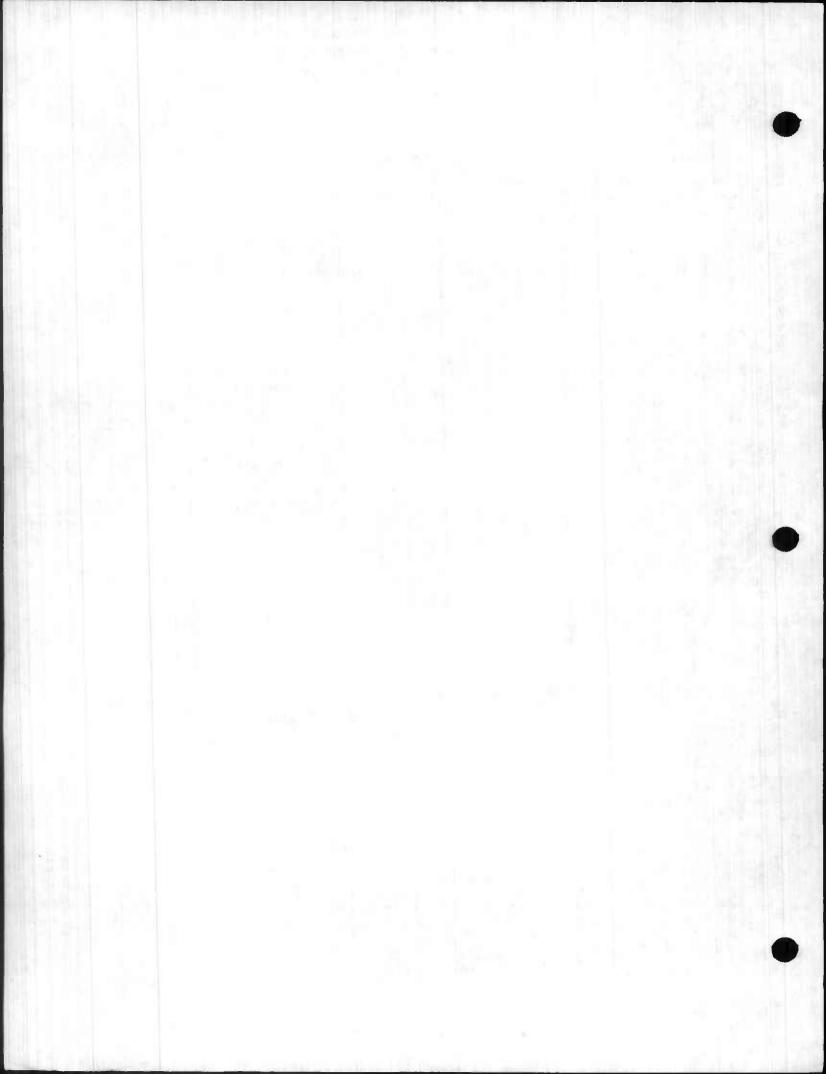


DHMH 16 Rev 6/95

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00

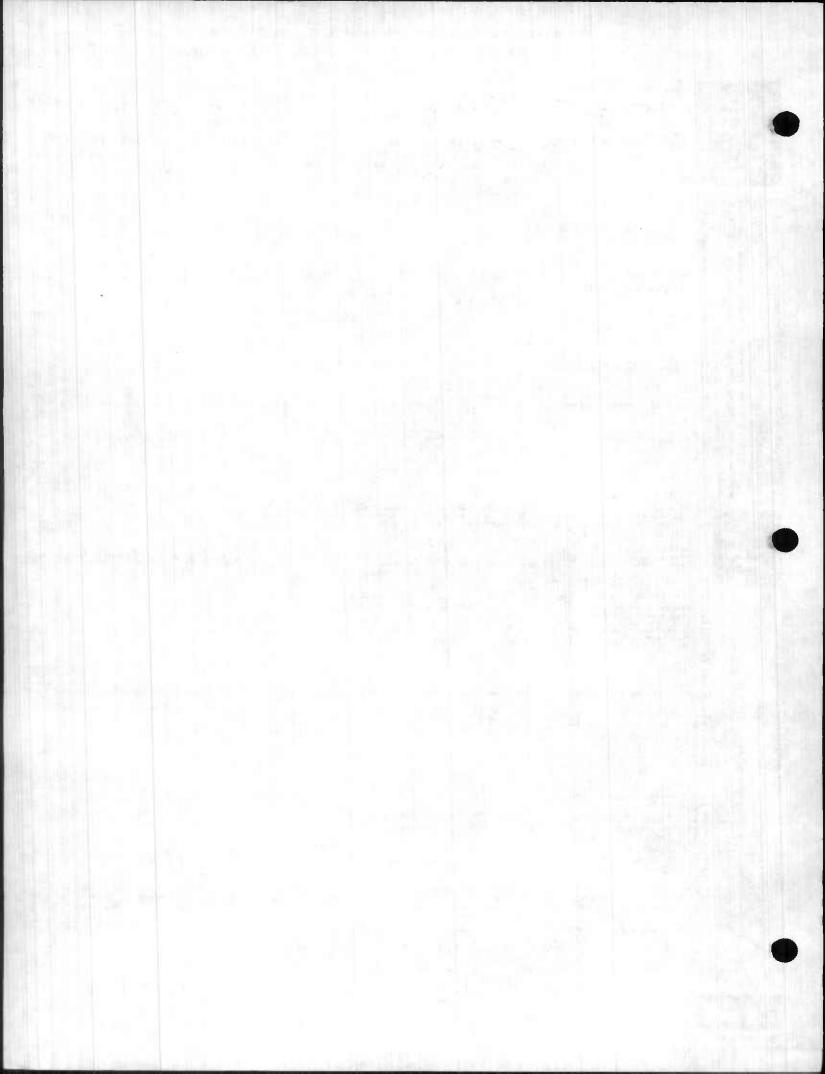
A	ASP amend	it	em 23a,b,27,28		,f per me				Death	2. Date of De	Reg. No.		3. Time of Death						
	Physici	an	1. Decedent's Name (First, Middle, Last)  ALEXIS HARTMAN							Month OCTOBI	Day	Yeer	10:30 A						
Ç.	/Medic	-	ALEXIS 4a Facility Neme (If no			ner)			4b. City, Town, or L				10.50 21						
	Examin	er		MEMORIA					HAVRE DE	E GRACI									
	Funeral Director		5. Sociel Security Number UNAVAILABL	er 6. S		. Age (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Deys 4 1	If Under 24 Hrs. Hours Min.	8. Deta of Bir (Month, Da 6/10/		9. Birthplace Country) WISCO	e (State or Foreign ONSIN						
	and		Usual Residence of De 10a. State 10	b. County		10c. City,	Town or Loca	ation				10d.	Inside City Limits						
	death with the Meryland ms 23s or 28s-f show												1 ☐ Yes 2 No						
	or 284	Director	10e. Street and Numbe				THE P	10f. Zip Code			10g. Citizen of V	Vhat Country	?						
	th wil	alD	2815 MIDDI	LEBORO C	COURT			21005			USA								
21215-0020	or No	by Funeral	11. Meritel Stetus  12 Never Married  3 □ Widowed 4 □		12. Was Deced Armed Forc 1 Tyes 2 If Yes, Give Year or Date	es?		as Decedent of I Yes, specify Cub	Hispanic Origin? (Spen, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Specify	e - American k, White, etc. WHIT							
5-0	72 hours "natural",	Be Completed	15. (Specify of	Decedent's Ed	ucation de completed)		(Give k	16a. Decedent's Usual Occupation (Give kind of work done during most of work)			16b. Kind of Bu	sinass/Indus	try						
121		mpt	Elementary/Seconda		College (1-4or 5+)			od)		(-									
	The last last last	S	N/A 17. Fether's Name (Firs	t Middle ( ast)				N/A	18. Mothar's Nam	e (First Middle	N/A Maidan Surnam	(e)							
Maryland	ges 1 and 2 should be filed to the filed to Heelth and Mental Hygell Hillem 27 is marked other or other treumetic event,	9 Be	MICHAEL H						KIM K		, , , , , , , , , , , , , , , , , , , ,	,							
2	2 should be and Mental is marked of sumatic ev	٩	19e. Informant's Neme		Type, Print)		19b. Malling	Address (Straa	t and Number or Rui		er, City or Town,	State, Zip Co	ode)						
	and 2 : selth ar n 27 is		MICHAEL & H			RENTS			ORO COURT		EEN, MD	21005							
re,	of Heelth of Heelth I Nem 27 r other tr		20a. Method of Disposi			20b. Pla	ce of Dispos	ition (Name of atory or other pla		Date	20c. Location -								
altimore,	2 2 4 5	DODE	1 ☐ Burial 2 🛣 C			ate MET		MATORY,		0/13/00	CATONS	WILLE	MD						
alti	Departm Departm Importa any Inju		21. Signature of Funer			TABL	22.	Name and Addre	ess of Facility			م تاملما ۱۸	MD						
m	Per se		Healt	will	Houses				ON FUNERA	-		0100							
		ıl 📗	23a. Part1. Enter the coshock, or heart ta	lisease, or com	olications that cer	used the deeth.	Do not ente	r the mode of dy	RAVEN BL' ing, such es cardiac	or respiratory a	WSON, ME	Ar	pproximata terval Between						
	Physician /Medical Examiner		er	er	er	er	er	er	Immediate Cause (Findisease or condition resulting in death)	el	a. ASPHYXL	Due to (or	as a consaqu	ence ot):					nsat and Death
	od dansit																		
68760,	ificate be executed physicien and as the bunal-transit																		
Box	death certife ettanding		d																
0	the et		Pert II. Other significant conditions contributing to death but not resulting in the underlying cau					derlying causa gi	ivan in Part I.	23b. Did tobacco use contribute to the cause of d			e cause of death?						
۳.	that the ned by th detache	Ph								1 Yes 2 No 3 Probably			oly 40 Unknown						
Records,	requires been sign should be	leted by	Completed by	by	leted by	leted by	leted by						J.		24a. Was	s an autopsy ormed?	eveila	autopsy tindings able prior to eletion of cause ath?	
Re	The law ate has t page 2 s	omi								1/3	¥es 2□No	1/234	fes 2 No						
of Vital		0	25. Was cese referred	to medicel					26. Place of Dea	-	10.100								
>		ToB	examiner? No Yas 2 No		Hospital: 1 🗆 In	patient 2 E	R/Outpatient	3 DOA OI	ther: 4 Nursing H	ome 5 Res	idence 6 Oth	er (Specify)							
	After fune	Certification: T	2 Accident	Death   28a. Date of thiury   28a. Date of t				28b. Time of A 28c. thiury at Work? 1 Yes 2 No			28d. Describe how injury occurred Suffocation								
Division	tal or Att	Certifi	3 ☐ Suicide 6 4 ② Homicida			28a. Place of Injury - At homa, tarm, streat, factory, office building, etc. (Specify)  home				281. Location (Street and Number or Rural Routs Number, City or Town, State) 2815 Middleboro Ct. Apt. C Aberdeen, MD									
	To the Hospital or Attend within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifiar 1 (Check only one)	Certifying Ph Medical Exam	ysician: To the b liner: On the bas and manna	is of examination	ledga, daath on and/or inve	occurred at tha t estigation, in my	ima, data and place, opinion, death occur	, and dua to the rred at the time	cause(s) and ma , date and place,	anner as state and due to th	ed. la cause(s)						
	To the Comp	Ž	29b. Signature and title	of cartifier		-2- 7.			se number	74	29d. Date signe								
		14	Den	mi	a. Chr.	t30		o.c.	M.E		OCTOBER	12,20	J00						
			30. Name end address	- 01/	empleted ceuse	of death (Itam :	23a) (Type, P		n Street,	Baltin	nore, Mar	ryland	21201						
	Sta Registr		31. Date tited (Month, I			gistrar's Signetu	B.	South	,										



State of Maryland / Department of Health and Mental Hygiene 00 32512

						Certifica	te of L	Death		Reg. No.	22312	
П	Dhysisi		1. Decedent's Name (First, Middle, Last)	11-		)			2. Date of Dee	eth Day Ye	3. Time of Death	
	Physicia /Medic		GEORGE	#6	NGON	V		PER COLUMN	10	100	0 1145A	
}	Examin		4a Facility Name (If not Institution, give s				4	b. City, Town, or	Location of Death	4c. County of I	A / \	
			Catonsville		nmo			Curon	revino	y pa	ltimore	
	Funeral Director		5. Sociel Security Number 6. Sex 2 14-D/-9517 154  Usual Residence of Decedent	M 2□ F	(In yrs. last bii	Yrs. If Under	Days	If Under 24 Hrs Hours Min.			Birthplace (State or Foreign Country) MARYLAND	
	ehow d m		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location								10d. fnside City Limits	
	Mary L	jo	MARYLAND BALTIMORE CATONSVILLE								1 ☐ Yes 2 ☑ No	
	7.28 1.04	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?									
	23a c		166 WINTERS LANE			11-11	21	228		U.S.A		
	9 4	Funeral		2. Was Decedent 6 Armed Forces?	Ever In U,S.	13. Was Deci	edent of H	ispanic Origin? (S In, Mexican, Puer	Specify Yes or No- to Rican, etc.)		American Indien, Vhite, etc.	
21215-0020	should be filed within 72 hours after death with the Maryland and Mental Hygiene. The Hygiene 128 or 288-f ehow metic event, the Medicel Examiner must be notified at	by	to Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 (XYes 2 □ No If Yes, Give Year or Dates: 41/43			The same	Specify:		Specify: BLACK		
2-0	72 h	Completed	15. Decedent's Educ (Specify only highest grade	etion		. Decedent's Usi (Give kind of w	ual Occup	ation during most of wo	rking	16b. Kind of Busin	ess/Industry	
2	de d	npl	Elementery/Secondery (0-12)	College (1-4or 5	+)	life. DO NOT	use retired	)				
ca .	filed with Hygiene Sther the	S	12th		M	ECHANIC		19 Mothor's Na	mo /First Middle	MILLER Maiden Sumame)	CHEVROLET	
and	od out	Be	17. Father's Name (First, Middle, Last)					10. MO(Her 5 IVa	ille (riisi, Middie,	Malden Sullame)		
Maryland	d 2 should be filed within 72 h th and Mental Hygiene. 7 te marked other than "natu traumatic event, tra Medical	2	SAMUEL HENSON	o Print)	101	Malling Addros	re (Street	SADIE		er, City or Town, Sta	te Zin Code)	
Ma	M 40 2		19a. Informant's Name/Relationship (Typ							Le, Md.,		
é .	ss 1 and of Health Item 27 other tr	-	Alton Morrison/Fri 20a. Method of Disposition	ena	20b. Place o	f Disposition (Na	ame of		Dete	20c. Location - Cit		
altimore,	Pages net: If Its iry or o		1 ⊠ Buriel 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)									
			21. Signeture of Funeral Service Licanse		GARR	ISON FOI	10-16-00	-00 OWINGS MILLS, MD				
Ba	permit. Departr Importu any inj		95/1 W	10	10	WILLI	AM C	BROWN CO		FUNERAL I	HOME PA	
		4	23a. Part 1. Enter the disease, a complic shock, or heart failure. List only on	ations that caused	the death. Do			TH AVENU g, such as cardia		rrest,	Approximate tnterval Between	
) F	Physician		shock, or heart failure. List only on	ause on each lin	10.				1		Onset and Death	
0	/Medical		Immediate Ceuse (Final disease or condition		1/1	mil	Mxd	rutine	buln	unury Dr.	inse Unhann	
	Examiner		resulting in death) a.		Due to (or es e	consequence of		000	10001	100.		
	D #	Ine	- h									
	tificate be asscuted g physician and as the buriel-transit	edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying		Due to (or es a							
68760,	ician burie	a E	Cause (Disease or Injury C.	С.								
387	phys the	D G	that Initiated events resulting in death) Last	#1975A	Due to (or as a	consequence of	):					
		-	d.									
Вох	atter	clar		stributing to death but not resulting in the underlying cause given in Part f. 23b.							hule to the source of deaths	
Records, P.O.	requires that the death cert sen signed by the attendin hould be detached for use	Physician/N	0	it not resulting i	in the underlying	cause giv	en in Part.		d tobacco use contribute to the cause of death?  ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown			
<u>ر</u> ،	ned b	by P	Still	mony					,,,	2010 0		
100	E 00 TO	8								an autopsy 2	4b. Were autopsy findings eveileble prior to	
000	s been 2 should	plet									completion of cause of death?	
٣ <u> </u>	The law ate has b page 2 s	Completed							10	Yes 2 No	1 Yes 2 No	
		Bec	25. Wes case referred to medical					26. Plece of De	ath (Check only o	one)		
>	Physicien: this certific ral director,	To	examiner? 1 Yes 2 No	ospital:	nt 2 ER/O	utpatient 3 🗆 🛭	Oth Oth	er: 48 Nursing	Home 5 Resi	denca 6 Other	(Specify)	
u ot	nersh		27. Menner of Death  1 Natural 5 Pending	28e. Date of Injui	Year) 28b.	Time of Injury	28c. Injur Wor	y at k?	28d. Describe	how injury occurred		
0	endir path. br: Ai	ate	2 Accident investigation			М	10	Yes 2□No				
Division	rector by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Placa of Inju- building, etc		arm, street, facto	ory, offica		28f. Location ( City or To		or Rural Route Number,	
0	retol											
	To the Hospital or Attending Physically A hours after death.  Jo the Funerel Director: After this completely filled in by the funeral di	edical	29a. Certifier (Check only one)  1 Certifying Physical Examin	er: On the basis of	examination ar	e, death occurre nd/or investigation	d at the tin on, in my o	ne, date end plec pinlon, death occ	e, and due to the turred at the time,	cause(s) and mann date and place, and	er as stated. I due to the cause(s)	
	the state of	Me	29b. Signeture end title of certify	and manner sta	led.	2	9c. Licens	e number		29d. Date signed //	Month, Day, Year)	
	18/		MAN	4	in		AT		Gray Tree Rd #300			
	N	1	20 Name and address of several to	noloted africa et a		(Tupo Bries)	1)0	דטכו		101101		
,	n lx	(	30. Name and address of person who cor	npieted cause of a	e mu		183	8 Gre	en T.	ree Rd	#300	
	S'a	te	31. Dete filed (Month, Day, Year)	32. Registra	ar's Signature			,				

DHMH 16 Rev 6/95

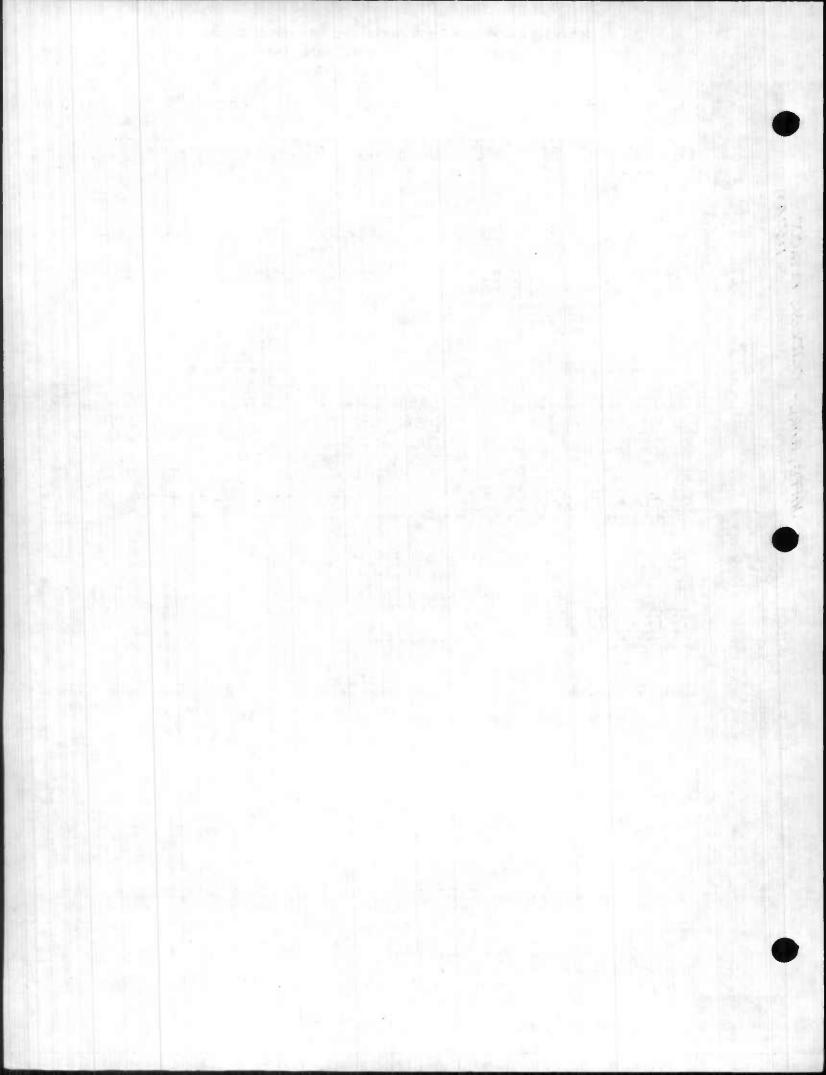


State of Maryland / Department of Health and Mental Hygiene 00 32513

			Ce	ertificate of	Death	Rec	1. No.	02010		
	1. Decedent's Nama (First, Middla, La	ist)				2. Data of Death		3. Time of Death		
Physician	EARL		J	AFFE		OCTOBER	12, 2000	1:50 AM		
/Medical Examiner	4a Facility Name (If not institution, give	re street end number)			4b. City, Town, or	Location of Death	4c. County of De	ath		
\$4) II	HOSPICE OF BALT	IMORE - GILC	HRIST CE	NTER	TOWSON		BALTIMOR	RE		
Funeral Director	5. Social Security Number 6. 5	Sex 7. Age (In	yrs. last birthday BO Yrs.	T 40		8. Date of Birth (Month, Day) AUG • 7, 1	920 9. B	irthplace (Stata or Foreign Country) MD		
4 8 %	Usual Residence of Decedent  10a. State 10b. County	110	o City Town or I	acetics				10d. inside City Limits		
a Maryla bart show diffied at	MD N		c. City, Town or L BALT	IMORE				1 X Yas 2 No		
n with the Ma 23a or 28a-1 aut be notified ail Directo	10e. Street and Number 5815 BERKELEY A	VENUE		10f. Zip Code	21215	109	U.S.A.	Country?		
ours after death virus after death virus after death virus 234 Examiner must by Furneral	11. Marital Status  1 □ Nevar Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Evan Amped Forcas? 1 2 Yas 2 □ No If Yes, Give Year or Datas:	in U,S. 13.	Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 🕱 No	Hispanic Origin? (Span, Mexicen, Puerl Specify:	pecify Yes or No- o Rican, atc.)	14. Race - An Black, Wh Specify:	nericen Indian, nite, etc. WHITE		
1 21215-0020 act within 72 hours ath vyliene. In the Medical Example Completed by F	15. Decedent's Education (Specify only highast grada completed)  Elementary/Secondery (0-12)  College (1-4or 5+)		(Giv	DO NOT use retire	during most of wor	rking	Sb. Kind of Busines	s/Industry		
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land in the file sealer Hy was other to Be O	SAMUEL	ide menana	JAFE	יבי	HILDA			WEISS		
T SAME P	19a. Informant's Name/Relationship	Type. Print)				urai Route Number, (	City or Town. State			
Me de	IRENE JAFFE / W					- BALTIMO				
more, and the sent of Hear and the sent of Hear and the sent of Hear and the sent of the s	20a. Method of Disposition  1 Burial 2 MCremation 3 D  4 Donetion 5 Other (Speci	Removal from State	0b. Place of Disp camatery, cre	osition (Name of ematory or other place (SERVICE (	ace)		TOWSON	or Town, State		
Balti permit. Departm Importer any Injur	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  SOL LEVINSON & BROS.,  8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21									
	23a. Part1. Enter the diseasa, or com shock, or heart failure. List only	Hung >						MD 21208		
Physician /Medical Examiner  Examiner  Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate		gest b (or as a conse to (or as a conse		y di	mlue		Onset and Death  G years  years		
Box 6876( ath certificate be attending physicia for use as the bur clan/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d	to (or as a conse							
P.O. the the ded by the detached	Part II. Other significant conditions			undarlying causa g		23b. Did tob		ris to the causs of death?  Probably 4 Unknown		
requires the been signed should be deted by	Hep	offitic C			7		. Was an autopsy performed?  24b. Were autopsy in available prior to completion of ce of deeth?			
The law ate has page 2:						1 ☐ Yes	28(No	1 ☐ Yes 2 ☐ No		
Vital I	25. Was case referred to medical examiner?				26. Piace of De	ath (Check only one	)			
this ald	1 Yes 2 No  27. Menner of Death 1 2Naturel 5 Pending	Hospital: 1 Inpatient  28a. Date of Injury (Month, Dey Ye	2 ER/Outpation 28b. Time Injury	of 28c. Inju	ury at ork?	forme 5 ☐ Resident 28d. Describe how		pecity) Hospiz		
or Attended after death of the birector: In by the ertifical ertifical ertifical and a second of the ertification and a second	2 Accident Investigation 3 Suicide 6 Could not be determined	e Ogo Place of Inium	At home, farm, s		Yes 2 No	28f. Location (Stre City or Town,	(Street and Number or Rural Route Number, own, State)			
To the Hospital To the Hospital To the Funeral I completely filled Medical C		nyalcian: To the best of my niner: On the basis of exa and manner stated.								
To the Within To the Comp	29b. Signature and the of partiller	In Ril	2000	1 0	25205	- 1	d. Date signed (Mo	-12 2mm		
19	30. Name and address of person who	GBINC(	16701	N. C	horles	St. Ba	lto. n	nd 21204		
State	31. Dete filed (Month, Dey, Year)	32. Registrar's	signature	1 1	4"					

ORIGINAL

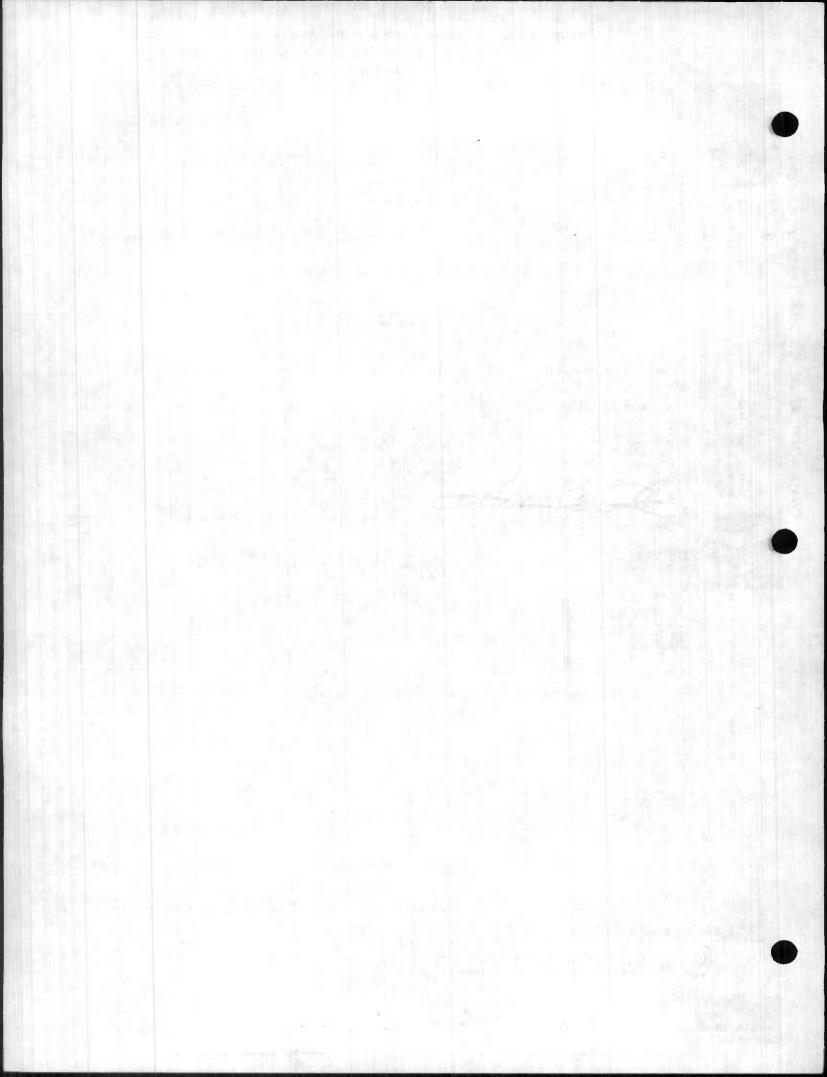
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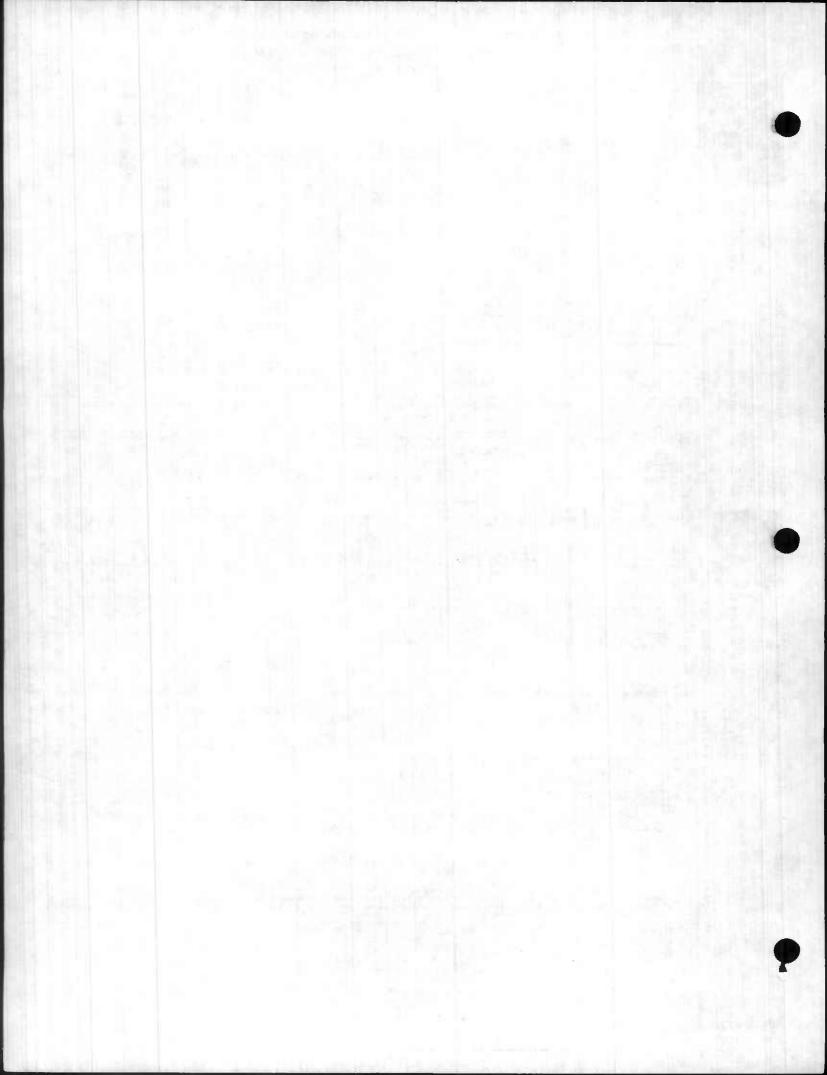
State of Maryland / Department of Health and Mental Hygiene 10 32511

				Certific	cate of	Death	F	leg. No.	0 0	2014	
200	1. Decedent's Name (First, Middle, L	ast)					2. Date of Dea Month	th Day	Year	3. Time of Death	
Physician /Medical	ROBERT HENRY	KIRCK	HOFF				October			11:40 PM	
Examiner	4a Facility Name (If not institution, gr	ive street and number	)			4b. City, Town, or L	ocation of Deeth	4c. County	of Death		
	Hospice of Baltim	ore Gilchr	ist Cer	iter		Baltimon	re	Bal	timore	2	
Funeral			ge (In yrs. last b		Inder 1 Yeer	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day	Year)	9. Birthplac	ce (State or Foreign	
Director	705-10-5697	1⊠M 2□F	82	Yrs.	iiii ooya	710010	Dec. 31	, 1917		Md.	
28 .	Usual Residence of Decedent		100 City To	um or Location					104	d. inside City Limits	
Show anything anything	Md. Baltimore   10c. City, Town or Location   Lutherville								100	1 ☐ Yes 2 ☑ No	
400M		ore	Luthe								
	10e. Street and Number			10	f. Zip Code			Og. Citizen of V		17	
ther death with the character of the cha	16 Felton Rd.				2109				SA	. In diam	
after dea	11. Marital Status	12. Wes Decedent Armed Forces	?	13. Was D	specify Cuba	lispanic Origin? (Sp an, Mexicen, Puerto	Rican, etc.)	Biad	e - Americer k, White, etc		
020 urs after at, or he		1 🔁 Yes 2 🗆 If Yes, Give		1 □ Y	es 201 No	Specify:		Specify			
215-0020(2) thin 72 hours after de an *naturat*, or ham and rail = am har in pleted by Fune	15. Decedent's E	Year or Dates:	*****	a. Decedent's	Heuel Occur	etion		16b. Kind of Bu	Whit		
od within 72 ho ygiene.  or then 'natural, the Medical Completed	(Specify only highest gi	rade completed)		(Give kind o	of work done	during most of world)	king	TOD. KING OF BY	3311033711120	Stry	
d within giene.	Elementary/Secondery (0-12)	College (1-4or				ice Manag		CSX Co	rn.		
d Hilled	17. Father's Neme (First, Middle, Las	(1)		, a , c , ,		18. Mother's Nam					
re, Maryland 212 s 1 and 2 should be filed within the Health and Mental Hygiene. It has marked other than other traumatic avent, the M	Henry Paret	Kir	ckhoff			Frieda	Mar	ie	Po	etzsch	
lary 2 shou and M 8 mark	19e. informant's Name/Relationship	(Type, Print)	19	b. Mailing Ad	dress (Street	and Number or Ru	ral Route Numbe	r, City or Town,	State, Zip C	(ode)	
and 2 and 2 and 2 resth au	Mr. Robert G. Kir	ckhoff/sor	1 1	.8819 Y	ork Rd	. Park	con, Md.	21120			
The THead	20a. Method of Disposition		20b. Place	of Disposition	(Name of		Date	20c. Location -	City or Town	n, Stete	
Pages nent of nr: If h	1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec					orp.	0/17/00	Tourson	n, Md.		
	21. Signature of Funeral Service Med	-	IIIIII						ii, iid.		
Balt parmit. Depart Importu any Inju	1000	1001	7	Ruc	k Tows	on Funera	of Facility n Funeral Home, Inc.				
	Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.										
Physician	shock, or heart failure. List only	y one cause on each	line.						li C	nterval Between Onset and Deeth	
/Medical	Immediate Cause (Final	F :	contact	2:21	1.	1	~			CIPAR	
Examiner	Immediate Cause (Final disease or condition resulting in death)  Livrhosis of Liver  Due to (or as a consequence of):									7	
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on of the same of	Control of the contro	l p				10 21 3			1	g corrs	
Exa	resulting in death) Last										
68760, ficate be en physician as the burla											
Box saturdin for use clan/N		d									
A . W. A	Part II. Other significant conditions	contributing to death	but not resulting	in the underly	vina ceuse aiv	ven in Pert I.	23b. Did t	obacco use co	ntribute to t	the cause of death?	
P.O. duty the Selection of Physics							101	ably 4 Unknown			
			1-1-1-1								
of Vital Records, Physician: The taw requires it this cardiciate has been signe mal director, page 2 should be d :: To Be Completed by								an autopsy med?		e eutopsy findings leble prior to	
e been s should							parior	illed i	com	pletion of cause sath?	
The tase page 2							101	es 2000	10	Yes 2□ No	
/ital I	25. Was cese referred to medical					26 Piace of Des	th (Check only o	^			
To B	examiner?	Hospital:	ient 2 ER/0	Outpatient 3[	DOA Oth	200:	ome 5□Resid		ner (Specify)	Hasniz	
Physics are 10 f	27. Manner of Death	28a. Date of Inj (Month, D		. Time of	28c. Injui Wo		28d. Describe h	-04		11040.4	
Many of the standard of the st	1 Naturel 5 Pending 2 Accident Investigati		ay rear)	Injury M		Yes 2 □ No					
Division of a standing P at a standard and Divector Ahar tall and in by the tuners Certification:	3 ☐ Suicide 6 ☐ Could not	A Zee. Piece of it	jury - At home,	ferm, street, fa	actory, office		28f. Location (S	Street and Numb	per or Rural i	Route Number,	
DIVI all or All all or All d in by	4 Homicide	building, e	ic. (Specify)				City or Tou	m, State/			
Hospita 24 hours Funeral Italy file dical C		hysician: To the best									
n 24 hos n 24 hos pleinty fi	(Check only 2 Medical Exa	miner: On the basis and manner s		and/or investig	ation, In my o	pinion, death occu	rred at the time,	dete end place,	and due to t	he cause(s)	
To the Hospital within 24 hours To the Funeral completely filed (Medical O	29b. Signature and title of centiller	1 1	10		29c. Licens			29d. Dete signe			
1 1 100	V C/ Hal	1 //	18.	us	0:	25205		Octo	ber 1	2000	
- All	30. Name and eddress of person who	completed ceuse of	death (Item 23)	(Type, Print)		1 0	. 0	01			
11.	11). A. Rilo.	7 66		701	N. G	harles S	7. Ba	cto, V	nd S	1204	
State	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature								

DHMH 16 Rev 6/95



I	MEND II	State of Maryland Pepartment of Health and EM: #20B PER F.H. G788 10-16- Pertificate of Death		giene	0 32515				
		Decedent's Name (First, Middle, Last)	2. Date of De Month		3. Tima of Death 8:10PM				
	Physician /Medical	Edith Lannon  4a Fscility Name (If not institution, give street and number)  4b. City, Town, or	October 15 2000  4b. City, Town, or Location of Death 4c. County of Death						
	Examiner	Brightwood Center Brooklandv		Baltimo					
ŀ	Funeral	5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hr	s. 8. Date of Bir		9. Birthplace (State or Foreign				
ı	Director	217-38-1767 1 M 2 KD F 95 Yrs. Months Days Hours Mir	April 29	1905	New Jersey				
u	P .	Usual Rasidence of Decedent  10a. State 10b. County 10c. City, Town or Location			40d Inclds City Limite				
	ahoo ahoo				10d. inside City Limits 1 ☐ Yes 2 ☑ No				
	the M	Virginia Fairfax Burke		10g. Citizan of W					
	iter death with the Marylar r theme 23e or 28e-f show near the notified at funeral Director	5801 Cove Landing Rd. #208 22015		US					
	ne 23	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (	Specify Yas or No		- American Indian,				
5-0020	0 0 0	Armed Forcas?  1 ☐ Never Married 2 ☐ Married  1 ☐ Yas 2 ☐ No If Yas, specify Cuban, Mexican, Pua  1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates:	rto Rican, etc.)	Specify:	k, White, etc. White				
0-0	ed within 72 ho ygjene. Ar than "natura A, the Molcell Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grads completed) (Give kind of work done during most of w	orkina	16b. Kind of Bu	siness/Industry				
2121	ithin 7	Elementary/Secondary (0-12) College (1-4or 5+)	UNING						
	Hygien the ont, the Cor	8 Homemaker	(E) . A(! ( II)	Own Ho					
Maryland	2 should be filed within 72 hours end Mental Hygiene. Is marked other than "natural", raumatic event, in HdT III. To Be Completed by		<sub>ame (First, Middle)</sub> celia Mitcl		9)				
K	marken marken marke	John William Cooke  Anna Ce  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or P			State Zin Codel				
Ma	d 2 sho th end 7 la m traum	Marlene Watson/ Daughter 5801 Cove Landing Rd. #20			Sidile, Zip Gode)				
re,	ges 1 end 2 should be filed within 72 hi t of Health end Mental Hyglene. If item 27 is marked other than "natu or other traumatic event, the Hisfiral To Be Completed	20a Method of Disposition 20b, Place of Disposition (Name of			City or Town, State				
Baltimore,	Pages nent of lint: If its iry or o	1 Burial 2 XI Cremation 3 Removal from State 4 Donation 5 Other (Specify)  A Donation 5 Other (Specify)	10 17 00	Towson,					
altin	교육한국	21. Signature of Funaral Service Licensee // 22. Name and Address of Facility	.09	101100113					
ä	Depa Impo	Fangling Ruck Towson Fupera	1 Home, In	BOA					
		23a. Part1. Enter the disease, or complications had couled the death. Do not enter the mode of dying, such as cerdishock, or heart failure. Listority one cause on each line.		rrest,	Approximate				
	Physician	Shock, of hear failure. Clistotly one cause of each line.			Interval Between Onset and Death				
	/Medical	Immediate Cause (Final disease or condition resulting in death)  a. ATHENOSCIENOTIC CANDIA VAS	renian	7/1	YRS				
	Examiner	resulting in death)  Due to (or as a consequenca of):							
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	ate be executed hysician and the bunal-transit	Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate gauss. Enter Underlying							
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89	p phys as the	resulting in death) Last Dua to (or as a consequance or):							
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_ •	es that the deeth certifical igned by the attending photo detached for use as the by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.	23b. Did	tobacco use con	tributa to the cause of death				
0.0	by the		10	Yss 2 No	3 Probably 4 Unknow				
	es thet be deta be deta		-		7				
Records,	been sign should be		24a. Was	an autopsy ormed?	24b. Were autopsy findings available prior to				
ec	has be				complation of ceuse of death?				
	Page C		1 🗆	Yes 200	1 Yes 2 No				
Vital	entific ector Be	examiner?	eath (Check only	one)					
of	hya his log I		Homa 5 ☐ Resi	dence 6 Other					
L C	After th funeral funeral	Matural 5 Pending (Month, Day Year) Injury Work?	280. Describe	now injuly occur	90				
Division	tal or Attending P rs after death. at Director: After t led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not be	28f. Location (	Street and Number	er or Rural Route Number,				
S	after after din b	4 ☐ Homicide building, etc. (Specify)	City or To	wn, State)					
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: Completely filled in by the Medical Certifical	29a. Certifler (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the fime, date and plan (Check only one)  Medicel Examinar: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ce, and due to the curred at the time,	ceuse(s) and ma date and place, a	nner as stated. and due to the cause(s)				
	To the Vithin To the complex Me	29b. Signature and title of certifier 29c. Licansa number		29d. Date signed	(Month, Day, Year)				
	N	1. Mr. 7mm & MM > 172033	3	10/1	6/00				
I	3	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		7					
	,0	16. ZONIGIMD 1838 aNGONITAG	E-Ni	PIK	ENILLE,				
	State	31. Data filed (Month, Day, Year) 32. Registrar's Signatura			MD 2/218				
	Registrar	OCT 1 6 2000 Denever G. Sparles							
DH	MH 16 Ray 6/95								



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Day Year **Physician** OCTOBER 6,24 AM RENE -LIZABETH 2000 /Medical 4a Fecility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPICE BALTIMORE RICHIE NIA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplaca (State or Foraign Country) **Funeral** 50 Days 214-40-892 1□M 2X F 5 Yrs. -16,1944 Director MAR Usual Rasidence of Decedant 10a. Sfefa 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or hems 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 1 Yas 2 No Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? 205 NORTH HAPEL STREET Funeral Was Dacedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Yaar or Datas: 1 Navar Marriad 2 Merried altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: BLAC by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry end Mental Hygiene. Elementery/Secondary (0-12) Collega (1-4or 5+) 2 HIGRADE TECHNICIAN TELEPHONE 17. Fethar's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Sumame) Be 2 should be f permit. Pages 1 end 2 should be Deperment of Health end Menta Important: If Nem 27 is marked any Injury or other traumatic events. HERMAN 2 IANIE (MN-UNKNEAN) RENE 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 2006 WESTWOOD AVENUE, BACTIMORE, MD. 2/2/7
ce of Disposition (Nama of Data 20c. Location - City of Town, Stata AUREN BROWN (DAUGHTER) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Burial 2 Cremation 3 Ramovel from Stata CEMETERY 4 ☐ Donation 5 ☐ Othar (Specify) ZION 10-16-00 LANSDOWNE, MARYLAND 21. Signature of Funerel Service Licensea 22. Name and Addrass of Facility BROWN JR. FUNERAL HOME JOSEPH 2140 N. FULTON AVE. BALTIHORE, HD. 2121 ams The Entar tha disease, or complications that caused tha death. Do not antar the mode of dying, such es cardiac or respiratory ick, or heart failure. List only one cause on each line. Approximete Intervat Between Onset end Deeth **Physician** Immediata Ceusa (Final disaasa or condition resulting in death) /Medical 5 years AIDS Examiner Due to (or as a consequence of): Examiner ician and burial-trans Sequantially list conditions, if any, laading to immadiafa cause. Enter Underlying Cause (Diseasa or injury that initieted events rasulting in death) Last Dua to (or as a consequence of): P.O. Box 68760 Physician/Medical the Due to (or es e consequança of). signed by the attending of be detached for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. p 24b. Wara eutopsy findings available prior to Completed 24a. Wes an autopsy performed? complation of cause of death? 20 No 1 Yas 1 Yas 2 No this certificate Division of Vital i or Attending Physician: after death. Director: After this certifica Be 25. Was casa refarred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Mothar (Specify) Horpica 2 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of Certification: 1 Natural 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicide 6 Could not be datarmined 28a. Place of Injury - At home, ferm, streef, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida To the Hospital of the To the Funeral D competely filled in 1 Certifying Physician: To the best of my knowledge, daeth occurred at the time, date and place, and due to the cause(s) end mannar es stated.

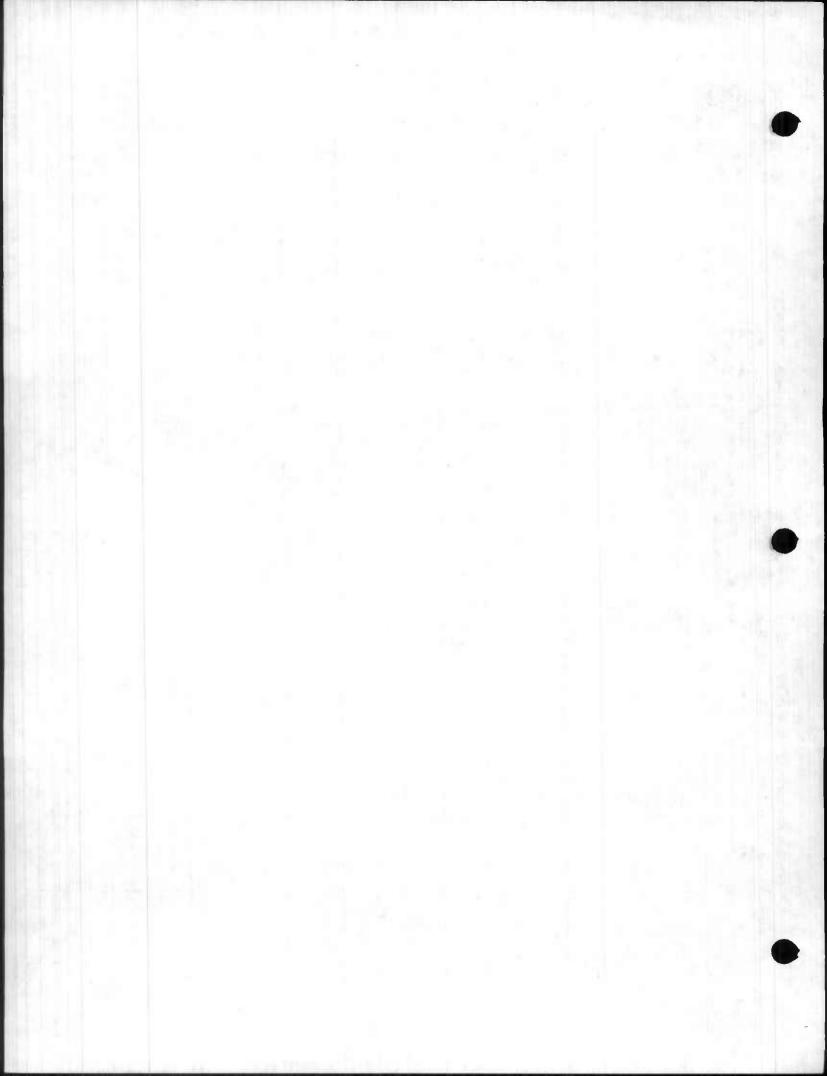
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and mannar stated. 29a. Cartifiar Medical (Check only one) 29b. Signatura end titla of cartifiar 29c. License number 29d. Data signed (Month, Day, Year) Benedick, ms Dovo 8583 10/11/2000 30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) BENEdict WILLAM N. Charles St 21204 6565 31. Data filed (Month; Day, Year) 32. Registrar's Signatura State Registrar DCT 1 6 2000

DHMH 16 Rev 6/95



	HESTER LEV	NIS 23a,27,28a,b,c,d,e,f pe		ryland / Depa /19/00 yf <i>Cer</i>			Mental Hy	giene () Reg. No.	0 3	2511	
П		Decedent's Name (First, Middle, Last)					2. Date of Death Month Day Year				
Q.	Physician /Medical	CHESTER 1.	EWIS				OCT.	7, 2000		1718 PM	
P	Examiner	4a Facility Neme (If not institution, given BON SECOUR HOS)	e street and number) PITAL			4b. City, Town, or BALTIMO		h 4c. County			
_		5. Social Security Number 6. S	Sex / 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bir	th	9. Birtholace	(State or Foreign	
ш	Funeral Director		ØM 20 F	Yrs.	Months Days	Hours Min.		Year)	Country)	SC	
-		Usual Residence of Decedent		10c. City, Town or Loc				1 00 1			
	ahow	10a. State 10b. County					Inside City Limits  1 ☑ Yes 2 ☐ No				
	Pe M	10e. Street and Number	7	BALTIMOR	10f. Zip Code			10g. Citizen of V			
	with with Dir	10-0	15		Tog. Oxizor or v	101					
	within 72 hours effer deeth with the Maryland ena. than "natural", or items 23s or 28s-f show its Wedferd Exercites result be notified at empleted by Funeral Director	4402 CORDELIA	12. Was Decedent Ey	ver in U,S. 13. V	Ves Decedent of	Hispanic Origin? (\$ pan, Mexican, Puer	Specify Yes or No	)- 14. Rac	e - American II	ndian,	
0	Tur.	1 Never Married 2 Married	Armed Forces?		/		to Rican, etc.)		k, White, etc.		
005	ralf, o	3 Widowed 4 Divorced	Year or Dates:	If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Year or Dates:				Specify	BLACK		
15-(	ed within 72 hours ygiena. or then "natural", it, ir.	15. Decedent's Ed (Specify only highest gra					orking	16b. Kind of Bu	usiness/Industr	У	
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d	ETES 0	17. Fether's Name (First, Middle, Last,	, 10/71	20140	, aucitor		me (First, Middle			70.4	
ılar		JOHN LEWIS			HATTLE	CLARK					
Maryland 21215-0020	d 2 should the and Men 7 is marke traumatic	19a. Informant's Name/Retationship (		19b. Mailin	g Address (Stree	t and Number or R	ural Route Numb	er, City or Town,	State, Zip Coo	de)	
	s 1 end f Health Item 27 other tr	DIANE LEWIS	SISTER	4902	CORDE	JA AVE	, BALTO.	mo.	21215		
lore	0 0 - 2	20a. Method of Disposition 1 Delial 2 Cremation 3 Delial 2 Delial 2 Delial 3 Delial	Removal from State	20b. Place of Dispos cemetery, crem	atory or other pla	ace)	Date	20c. Location -		State	
Baltimore,		4 Donation 5 Other (Specif		CREMATION	Name and Addr		10/12/06	BALTO.	MD		
Ba	Departr Importu eny inje	21. Signature of Funeral Service Licer	1500			SERVICE	25				
	6	23a. Pert1. Enter the disease, or com	nlications that caused the	51.	51 BALTO	NATL P	PIKE BA	LTO. MO		proximate	
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	и	AND ETHANOL use to (or es a consequence to the cons		ION			1		
	executed in end iel-transit	Sequentially list conditions, if any, leading to immediate	D	ue to (or as a consequ	uence of):						
8760,	sate be executed the bunel-transit dical Examir	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	C								
9	5 5 0	resulting in death) Last	Di	ue to (or as a consequ	ience or):						
Box	at the death certificate by the attending pletached for use as the tached for use as the		d						1		
.O.	the at hed fo	Part II. Other eignificant conditions of	contributing to death but	not resulting in the un	derlying cause g	iven in Part I.	23b. Dld	tobacco use co	ntribute to the	cause of death?	
0	- 02 -						1□	Yee 2 No	3 Probabl	ly 4 Onknown	
Division of Vital Records,	been sign should be							s an autopsy ormed?	availat	autopsy findings ble prior to etion of cause th?	
m.	The lew ate has page 2						13	Yes 2□ No	1 X Ye	es 2 No	
/ita	certificate rector, pag	25. Was case referred to medical examiner?					eath (Check only	one)			
of	hya his	1 X Yes 2 No	Hospital: 1 Inpatien		3LI DUA		Home 5 Res				
no	After funer funer	27. Manner of Death  1 Naturel 5 Pending investigation	found:	Year) found	P 28c. Inj	ork? ]Yes 2.182No	unknown	how injury occur	red		
Division	To the Hospital or Attending P within 24 hours after death. To the Funeral Director. After t completely filled in by the funer Medical Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur building, etc.		City or To	(Street and Number, State) 162	3 Bakbur	y Court			
	To the Hospital within 24 hours To the Funeral completely filled		found:res	my knowledge, death			e, and due to the	cause(s) and m	anner as state		
	the Hosp nin 24 hou the Funer npietaly fil	one) A	niner: On the basis of e and manner state				enii eni is peno				
	within To the comple	29b. Signature and title-el certifier	1 1	1. 1		.C.M.E		OCT.	8, 200		
		1/	1.7,1	NID,		• • • • • • • • • • • • • • • • • • •		001.	0, 200	50	
		30. Name and address of person who				, Baltimo	ma Max	rland 21	201		
	State	31. Date filed (Month, Day, Year)	32. Registrer		DITECT	, DOLCHIK	re, nat	Y TORK ZI	.201		
	Registrar	OCT 1 6 200	00	/							

DHMH 16 Rev 6/95



# 50a 0 2000 Detoper

#### 2. Date of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Dey **Physician** MAROCCO MONI OCTOBER 2000 15 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner BALTO ILLAGE CARE CENTER If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Months Days Hours Min 220-14-0113 Director October 30,20 Baltimore, Md Usual Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Baltimore Co. Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8810 Walther Blvd. Items 23s Apt. 1321 U.S.A. 21234 Funeral 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. I is marked other then "natural", or item traumatic event, the Medical Example: Black, White, etc. 72 hours after 1 ⊠ Yes 2 □ No If Yes, Give ↑ Year or Dates: 1 □ Never Merried 2 Narried 1 ☐ Yes 2 Ho Specify W.W.II Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 4 Self Employed Contractor Construction Maryland 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middle, Last) 2 should be fi and Mentel F Pio Joseph Marocco, Sr. Rosa D'Ercole 19e. Informent's Name/Relationship (Type, Print) (Wife) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Peges 1 and 2 of Haalth a Mrs. Anita Laura (nee Cipolla) Marocco 8810 Walther Blvd. Apt. 1321 Baltimore, Md. 21234 Saltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Department of Important: If It any Injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 □ Donetion 5X10ther (Specify) Entombment Lorraine Park Cemetery 10/18/00 Baltimore, Maryland 22. Name and Address of Fecility Jeffrey L. Gair Ruck Towson Funeral Home, Inc. Mr 1050 York Rd. Towson, Md. 21204 for the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, flearly failure. List only oppositions on each line. Approximate interval Between Onset end Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) FARS Examiner Due to (or as e consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initieted events resulting in death) Last Due to (or es e consequenca of): Box 68760, Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? P.O. Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 10 Y68 20 No 3 Probably 4 Unknown à Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Medical Certification: To Be Completed page 2 1 ☐ Yes 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: 25. Was case referred to predical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Nd After this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation setter deeth. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 | Homicide 24 hours

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

State Registrar 29e. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

To the Hospi within 24 hours To the Funer completely fil

**DHMH 16 Rev 6/95** 

1 6 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RED SRKES MID, 8800WALTHER

32. Registrer's Signeture

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated.

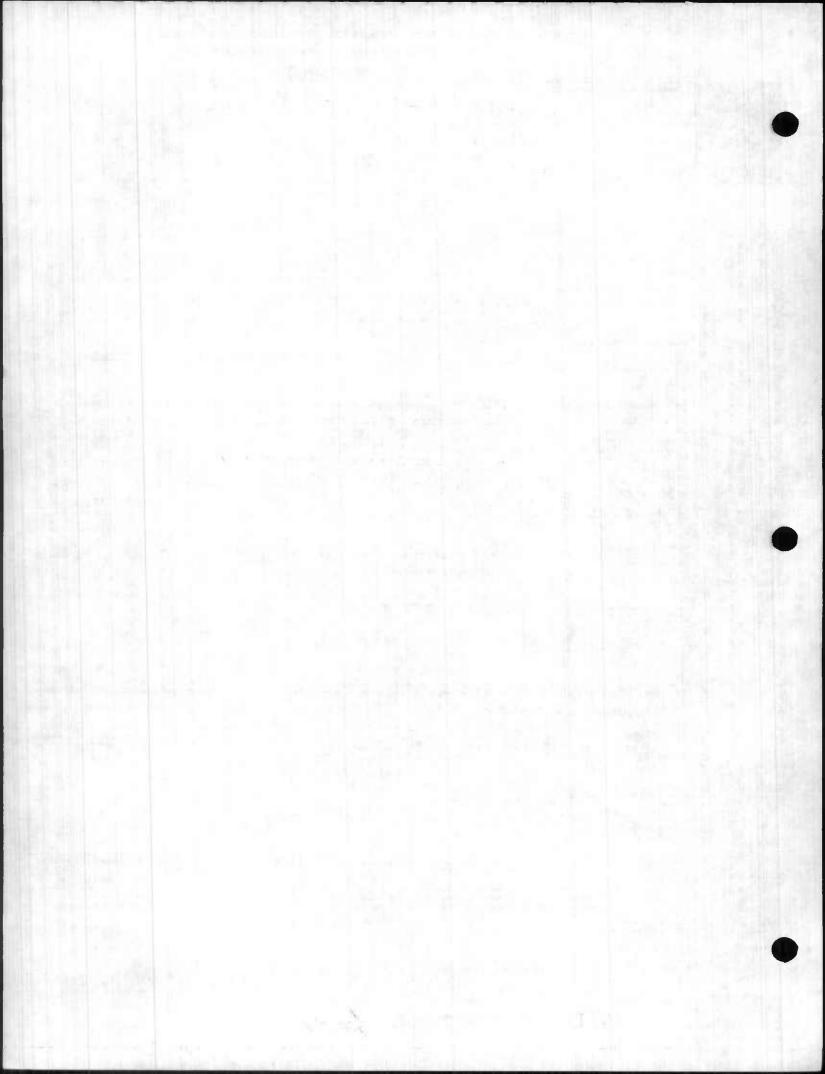
29c. License number

29d. Date signed (Month, Day, Year)

10

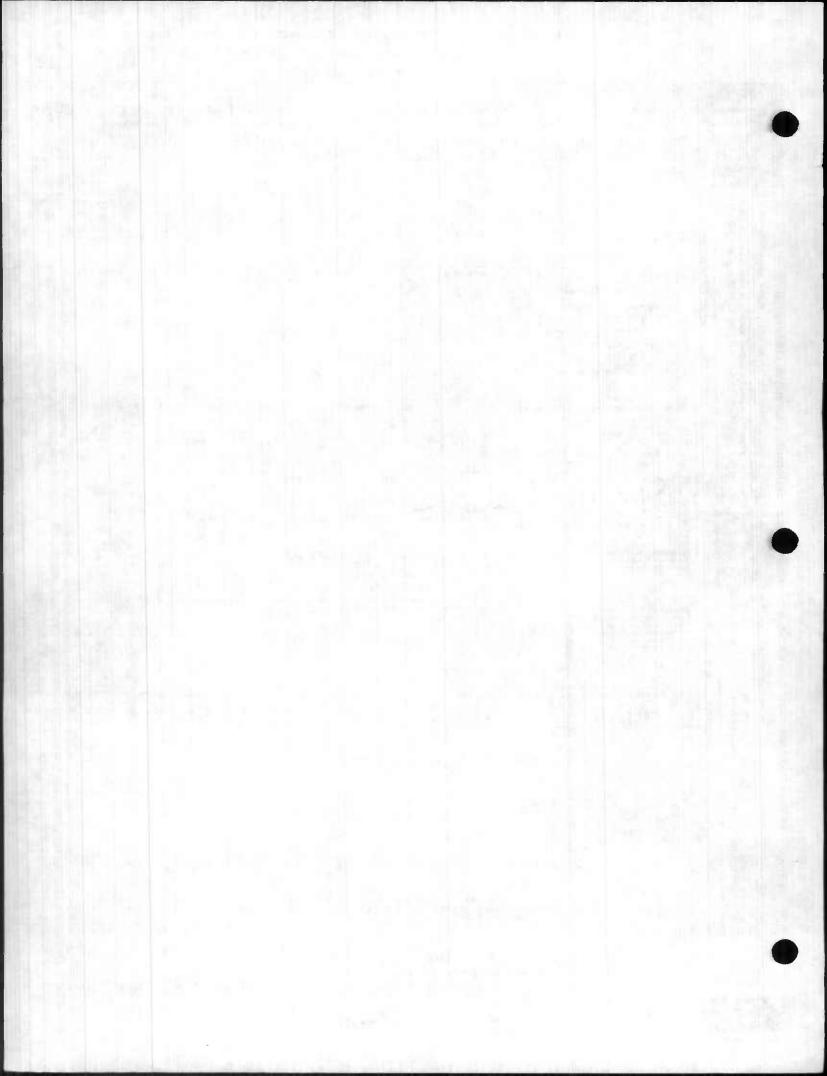
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State of Maryland / Department of Health and Mental Hygiene 00 32519

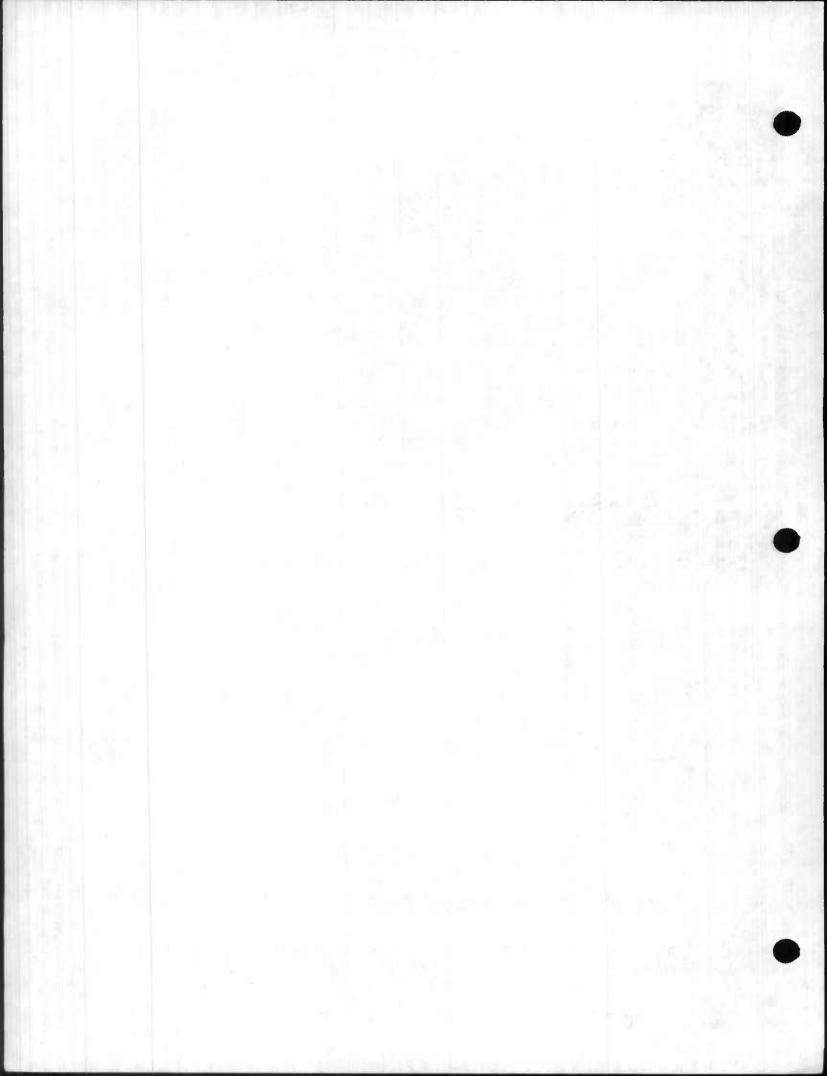
				C	ertifica	te of	Death		Re	J. No.		0 2 0 1 3
		1. Decedent'a Name (First, Middle, La	ist)						2. Date of Death	D.	Vee	3. Time of Death
	hysician	ELSIE	MEOI	MARTINO	)				Month	Day	Year	2.00 pm
5.	/Medical xaminer	4a Facility Name (If not institution, gir		() () ()	T-A		4b. City, To	wn, or Lo	ocation of Death	4c. County	-	
-	Xammer		SAYVIEW M	EDICAL C	FNTE	R	BALT	TIMO	DRE	N	I/A	
				(In yrs. last birthda		er 1 Year					,	place (State or Foreign
	neral ector		1□M 2ŽJF	85 Yrs	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, 1	Q15		place (State or Foreign
Dif	ector	Usual Residence of Decedent		05		1			0-10-1	.71.7	MA	RYLAND
and .	1	10a. State 10b. County		10c. City, Town or	Location			47.1			1	10d. Inside City Limits
lan	T I	MD BA	LTIMORE				RA	SPE	BURG			1 ☐ Yes 2 ☑ No
9	Se B				1.00				146	000		**
E	- H	10e. Street and Number	VZ ATSVII ITS		101. 2	ip Code	21206		10	g. Citizen of	U.S	
5	ust be notified at	5458 CEDONIA	AVENUE				21200	)			0.5	•A•
21215-0020 within 72 hours after death with the Maryland ene.	remarks of 2007	11. Marital Status	12. Was Decedent E Armed Forces?	iver in U,S. 1	3. Was Dec	edent of H	lispanic Ori an, Mexicar	gin? (Spo	ecify Yes or No- Rican, etc.)		ce - Ameri ck, White,	can Indian, etc.
5 g		1 Never Married 2 Married	1 Yes 2X N		1□ Yes		Specify:					
20 5	0	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 1 168	201140	эресну.			Specif	y: WH	ITE
21215-0020 d within 72 hours af giene.	Completed by	15. Decedent's E	ducetion	16a. De	cedent's Us	ual Occup	ation		10	6b. Kind of B	usiness/în	dustry
Pin 7	pie ei	(Specify only highest gri	College (1-4or 5-	life	ive kind of w B. DO NOT	use retire	d) mos	t Or WORK	ing			EWELRY
	dwo	10	College (1-401 3		SISTA	NT MA	ANAGER	?		S.	TORE	
		17. Father's Name (First, Middle, Last	)		, OI OIII				e (First, Middle, M.	aiden Sumer	ne)	
ylan buld be Mental		MARTIN VANHO	RN				I A	LBEI	RTA (	DORSE	Y)	
should and Men	marke a	19a. Informant's Name/Relationship	Time Print)	10b M	niting Addres	se /Street	and Numbe	or or Run	el Route Number,	City or Town	State 7i	n Code)
Maryland Id 2 should be file Ith and Mental Hy		HOWARD MEOMARTIN			CEDO				ALTIMORE,		21206	
	2 2		O (HODDAM				IVERIOR	J 17				
Baltimore, semit. Pages 1 ar Department of Hea	e de	20a. Method of Disposition 1 ☐ Burial 2XX Cremation 3 ☐	Removal from State	20b. Place of Di cemetery, o	rematory or	other pla	ce)	1	100	Dc. Location	150	
Pages nent of	ייי	4 □ Donation 5 □ Other (Speci		METRO	CREMA	TORY			10/12/00	BALT	IMORE	C,MD
Departm	any injury	21. Signature of Funeral Service Lipe	gseo /		22. Name a	and Addre	ss of Facilit	y CV	ACH/ROSEI	ALE FI	INFRA	J. HOME
n 28	any to	1 mm	2 ( ( )	/_	1211	CHES	ACO AT		E ROSEDA			237
		234. Parti. Enter the disease, or con	polications that sound	the death. Do not						-		Approximate
		shock, or heert failure. List only	one ceuse on each lin	6.	anter the mic	oue or cyn	rg, 3001 a3	Coldide	or respiratory arres	,		Interval Between Onset and Death
Phys	_										1	- 4 - 4
	dical niner	Immediate Cause (Final disease or condition	INTRA	ACRANIA	IL K	EMO	RRHI	MUE			:	IDAY
LAUII		resulting in death)		Due to (or as a con	sequence of	):					1	
D	in and side transit Examiner										1	
cute	an Em	Sequentially list conditions,	0.	Due to (or as a con	sequence of	):						
5 °	E P	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									1	
certificate be execut	physician and is the burial-transit edicai Examin	I trial miliated events	С.	ue to (or as a con:	sequence of	):					-	
D E		resulting in death) Last										
BOX	esn &		d									
death	Cia Cia								000 Distant			
De of the d	be detached for us by Physician/	Part II. Other significant conditions	contributing to death bu	t not resulting in th	e underlying	ceuse gr	en in Parti			-		to the cause of death?
r tat	P Sept	ASTHMA							1 □ Ye	2 No	3 Pro	bably 4 Unknown
8 5	cate has been signed by the attend , page 2 should be detached for us.  Completed by Physician/					11.17					T	
OrdS	should should etech								24a. Was an perform		av	fere autopsy findings vailable prior to
e v	2 sh							_		9	O	ompletion of cause deeth?
T e	Page								1 ☐ Yes	RE No	1	☐ Yes aDNo
	o o	25. Was cese referred to medice!					26 Place	of Dont				
OT VITE	iractor, page 2	axaminer?	Hospitel:			Oth Oth	nor:		h (Check only one		/ 0	94.3
	T de	1 Yes 2 No 27. Manner of Death	1 Inpatier 28a. Date of Injury			JUA	4U N		ome 5 Resider			ny)
E Bu	E CO	1 Neturel 5 Pending	(Month, Dey		У	28c. Injui			200. Describe no	willing occu	1100	
Attending r death.	the cat	2 Accident investigation 3 Suicide 6 Could not be	NO.		М		Yes 2		201 1 12 10			-18
> 4 5	4	4 Homicide determined	28e. Plece of Inju building, etc.	ry - At home, farm, . <i>(Specify)</i>	street, facto	ory, office			28f. Location (Str. City or Town,		ber or Hui	ral Houte Number,
5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Certification:											
hour	a la	29a. Certifier 1 Certifying Pl	nysician: To the best of	my knowledge, de	eth occurre	d at the ti	me, date an	d place,	end due to the car	use(s) and m	anner es	stated.
the Hospital	Medical Certification:	(Check only 2 Medical Examone)	miner: On the basis of and manner stat		investigatio	я, in my c	pinion, dea	un occur	red at the time, da	e and place,	and due	to the ceuse(s)
0	W Gira	29b. Signature and title of certifier			2	9c. Licens	se number		29	d. Date signe	ed (Month	Day, Year)
H-53	10	1 donutas		6 8		01	101,0	7	^	CTUBER	11	2000.
11		Re	200	pellan		1 1	147	1	0	CLODEK	11	
0	NOV	30. Name and address of person who	completed ceuse of de			216			OF INTA	0 4:-	11-14	
1		ABHAY MOGHEK	AR , JOHN		BAY	HEW	MEDI	CAL	CENTER,	BAUT	MORG	MU
	State	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	1		- 3					
	onietrar	131. 1 1 / / / / / / / / / / / / / / / / /	170 000	- /-/	An.	20						



# FANNIE MOORE

		State of	of Marylan		rtment of F tificate of	lealth and M <i>Death</i>		iene og. No.	00 3	2520
Dhomining	1. Decedent's Nama (First, Middle	e, Last)			1 1		2. Date of Deat Month	h Day	Voor	ima of Death
Physician /Medical	Fannie V	irginia	Moore				10		00	345 PM
Examiner	4a Facility Nama (If not institution					4b. City, Town, or Lo		4c. County of		
	Noble House					Baltimo		N		
Funeral Director	5. Social Security Number 214-24-0823	6. Sex 1 □ M 2 □ F	7. Aga (In yrs. 77	last birthday) Yrs.	Months Days	If Undar 24 Hrs. Hours Min.	8. Deta of Birth (Month, Day, 02-20	Year) -23	9. Birthplaca (S Country)	Stata or Foreign MD
2	Usual Rasidenca of Decedent		40. 00		. Al					
anyle	10a. Stata 10b. County	NA		y, Town or Loc ltimor						Sida City Limits  ☐ Yes 2 ☐ No
or 28a-f a		IN A	Da.	LCIMOL						3100 2 110
death with the Maryland one 23e or 28e-f show cross be not seed and one at Director	10e. Street and Number 2842 Woodbro	ok Aveni	ue		10f. Zip Code 2121	7	1	og. Citizan of W USA	nat Country?	
- P - P - P	11. Marital Status  1 Nevar Married 2 Mar	ied 1 ☐ Yas	2 No		/as Decedent of H Yas, specify Cub	dispante Ortgin? (Span, Maxican, Puerto Specify:	ecify Yas or No- Rican, etc.)	Black	- American Ind k, Whita, atc.	
D L L	3 Widowed 4 Divorced	Yaar or E	Datas:	16a. Deced	ent's Usual Occur	pation		Specify: 16b. Kind ol Bu	втаск	
1 21215-0020 ed within 72 hours el ygiene. ver than "natural", or rt, fre Medical Essan Completed by I	(Specify only highe Elementary/Secondary (0-12)	completed) Collega (		(Giva A life. D	ind of work dona O NOT usa retire	during most of work	ing		Ti. A.	
	10th Grade 17. Father's Name (First, Middle,	NA		Nurs	е	18. Mothar's Name	/First Middle A	Hospi		
E Sega	Rufus	Langto	on			Leslie			ntine	
should and Men	19a. Informant's Name/Relations			19h Mailine	Address (Straat	and Number or Run				)
	Mary Brown					shade La				
Fe, Theal free other	20a. Mathod of Disposition	20.00	20b. P	lace of Dispos	ition (Nama of atory or other pla			20c. Location -		
Pege ent o st: If if	XDxBurial 2 Cramation 4 Donation 5 Other (S		Stata			Pk. Cem	10-1	7-2000	Arbut	us. MD
Baltimore, permit. Peges 1 at Department of Hee Important: If Item any Injury or othe page.	21. Signature of Funaral Sarvice				Nama and Addra	5 F106	altimo			
D FEEE	1 4 8 a 8 a	w		WM	. C. Ma	arch FH			-	
-	23a. Part1. Enter tha disaesa, ol shock, or haart failura. List	complications that	caused the deat						Appre	oximate vel Batween
Physician	Shock, or heart failure. List	Only Ona Cause On a	adori iirio.							it end Deeth
/Medical	Immediata Causa (Finel diseasa or condition		SM	OKE					6.	MONTHS
Examiner	resulting in daath)	a.		r as a consequ	uanca oi):	17-15-7				
od sir		b								
8 / 60, sate be executed thysicien and the bunal-trensit dical Examiner	Sequentially list conditions, if eny, leading to immadiata cause. Entar Underlying Cause (Diseasa or injury	1937	Dua to (o	r as a consequ	uance of):					
ate be en hysiclen the burie	cause. Entar Underlying Cause (Diseasa or injury that initiated avants	с	Due to (e					·	-	
	rasulting in death) Last		Due to (o	r es e consequ	ience oi):					
BOX 68 leath certific attending pl for use as 1		d								
_ 0 0 0	Part II. Other significant condition	one contributing to d	eath but not ras	ulting in the un	derlying ceusa gir	ven in Part I.	23b. Did to	bacco use con	tribute to the o	cause of death?
ords, P.O. BOX of requires that the death certification is good by the attending in hould be detected for use as atted by Physician/Me	Partalis	Ulu	-				1 🗆 Y	2 No	3 Probably	4 Unknown
ires that signed by detailed by P							040 11/100		24h Ware au	toney findings
0 0 0							24a. Was a perforr	n autopsy ned?	available	ion of cause
The lev page 2							1 D Y	s 2 No		2 No
VITAL IN Intelement The Contificate rector, pag	25. Was cesa rafarred to medice					26. Place of Deat				
	axaminar? 1 ☐ Yas 2 ☑ No	Hospital:	Inpatiant 2	ER/Outpatient	3 DOA OH	000	me 5 Reside		er (Specify)	
0	27. Mannar of Death	28a. Date	-	28b. Tima of Injury	28c. Inju Wo		28d. Describe ho			
ath.  After he funeration	1 Natural 5 Pandir 2 Accident investi	gation	, _u, . u.,	qui y		Yes 2□No				
DIVISION ( bal or Attending P rs after death. al Director: After id in by the funer Certification:	3 ☐ Suicida 6 ☐ Could 4 ☐ Homicida detarm	load 288. Place	e of Injury - At ho ling, etc. (Specifi	oma, farm, stra	et, factory, offica		28f. Location (St City or Town		er or Aural Aout	ta Number,
DIVISION Hospital or Attend 24 hours after death Funeral Director: analy filled in by the dical Certifical	00- 0									
		Examiner: On tha b				ma, data and place, opinion, death occur				ausa(s)
To the	29b. Signature and title of certifia				29c. Licens	se number	2	9d. Data signed	(Month, Day, 1	Year)
1	Mul	l MO			D:	38675		10/13	3 00	
176	30. Name and addrass of person	who completed ceus	sa of death (Iten	23a) (Type, F		- 0 - 1 /				
0)	JOEL MESHU	LAM ;	301 55	PAUL	PL SU	17E 60	5 342	MONE	MD 2	21202
State	31. Data filed (Month, Day, Year)		Registrar's Signa		1					
Registrar	OCT 1 6	2000	Genava	1	fig acid	3				-

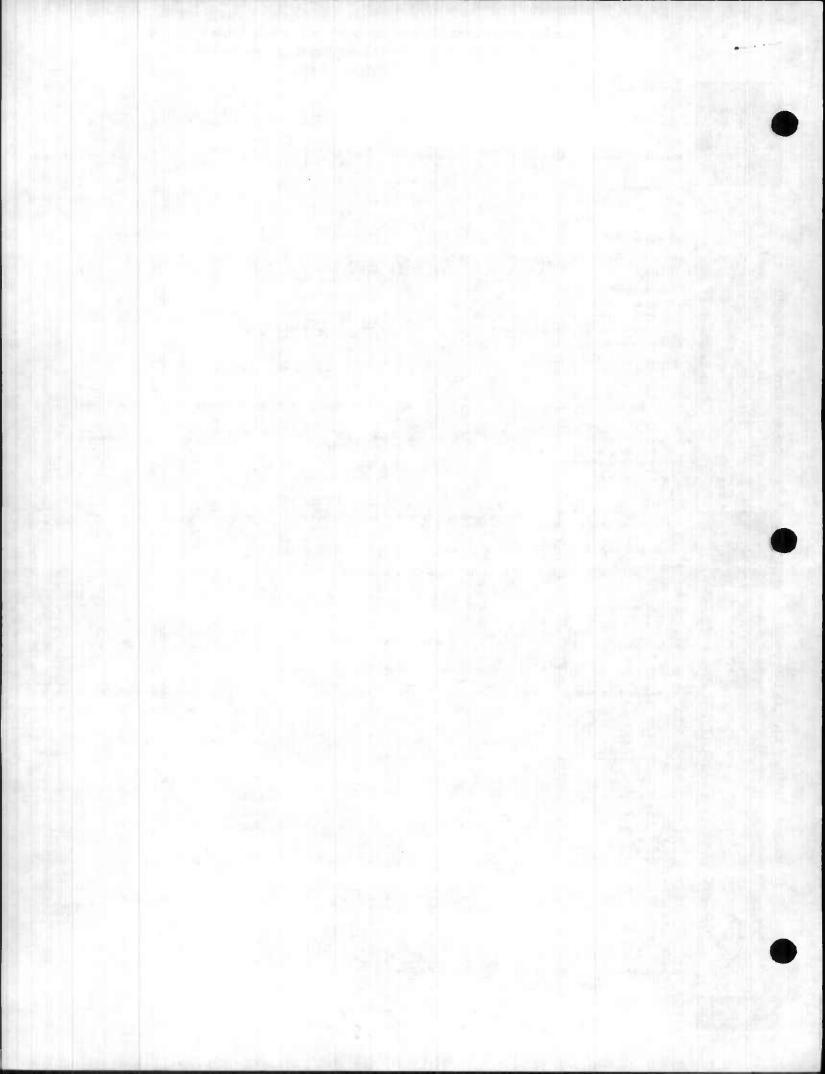
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State of Maryland / Department of Health and Mental Hygiene

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					Cei	rtificate	of	Death			Reg. No.	00	06	121
		1. Decedent's Neme (First, Mid-	dle, Last)	-11-1-1-1						2. Dete of De				ne of Deeth
-	Physician	Jacob	Miles							Month OCt.	Dey	2000		:02pm
	/Medical Examiner	4e Facility Neme (If not instituti		mber)		Late	-	4b. City, To	wn, or Lo	cation of Deat	h 4c.	County of D		
	Examiner	Good Samari	tan Hosp	ital			1	Balt	imon	ce		NA		
	Funeral	5. Sociel Security Number	6. Sex	7. Age (In yrs. last	birthday)	If Under 1		If Under Hours	24 Hrs. Min.	8. Dete of Bir (Month, Da	th Year	9. 8	Birthplace (St.	ate or Foreign
	Director	216-24-7622	10M 20F	69	Yrs.	Months	Deys	nours	MIN.	03-04	-31		N	C
ь	· ·	Usual Residence of Decedent												
	show	10a. Stete 10b. Count		10c. City, T										de City Limits
	r 28a-1 show Frootfied	MD N	A	Bal	timo	re							xx	Yes 2 No
	deeth with the Maryland ms 23s or 28s-f show fraunt to modified m neral Director	10e. Street and Number				10f. Zip (	Code				10g. Citi	zen of Whet	Country?	
	with w	1112 Lakewo	od Avenu	e		212						USA		
		11. Meritel Status	Armed Fo		13.	Was Decede It Yes, specif	nt ot H	lispenic Orl an, Mexicar	gin? (Spo n, Puerto	ecify Yes or No Rican, etc.)	-	14. Rece - A Bieck, W	merican Indie hite, etc.	in,
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8	"natural", "natural", ideal by				So Donn	dontin I lavat	00000	etien			1ch Ki	nd ot Busine	Blakc	
21215-0020	yglene. naturn, v.	(Specify only high	nt's Education est grade completed)		(Give	dent's Usuet kind of work DO NOT use	done	during mos	t of work	ing	TOU. KI	ING OF BUSINE	ssindustry	
12	be filed within ital Hyglene. d other than avent, the Be Comple	Elementery/Secondery (0-12)	College (1			k Dri					T. c	cal	Union	#557
	H H H	17. Father's Neme (First, Middle			rruc	K DE	ve		er's Neme	e (First, Middle	_		0111011	11331
lan			Mile	S				Fra	nces		Car	zer		
Maryland	2 should be filed vent and Mental Hygie is marked other taumatic event, in To Be Co	19a. Informent's Neme/Reletion			19b. Meitir	ng Address (	Street			al Route Numb			e, Zip Code)	
	Ol m m e	Carrie Mil	es		1112	Lake	ewo	A bo	veni	ie Bal	timo	ore,	MD. 2	1213
e,	of Health frem 27 other tr	20a. Method of Disposition		20b. Plec	e of Dispo	sition (Nem	e of			Dete			or Town, Ste	
Baltimore,	Z :: Sa	1 Buriel 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (		State					ns il	10-16-	2000	) D11	ndalk	, MD
=	- 독특류	21. Signeture of Funeral Service				2. Name end				altimo				
B	Department of the partment of	Barnal	820.6						טכ			-		1202
		23a Part Foter the disease	or complications that of							LO1 E.		rtn A	Approx	rimete
	Dhysisian	23a. Part1. Enter the diseese, shock, or heert teilure. Li	st only one ceuse on e	ech line.									Interve	l Between end Deeth
	Physician /Medical	tmmediate Ceuse (Finel		ARYTH	1 44	٨							i	
	Examiner	disease or condition resulting in deeth)	a	Due to (or es		-								
L	<u> </u>			ENDST	ACF	- O	PAI	Ar	DV	FASE	2			
	physician and street be executed physician and street bunist-transit	Sequentially list conditions	b	Due to (or es	e consec	uence ot):	1-10	In	UE	1-11/1-				
ó	an ar inial-t	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events												
68760,	certificate be exending physician ause as the bunal-	Ceuse (Diseese or injury thet initieted events resulting in deeth) Last	С.	Due to (or es	e conseq	juence of):								
99	ing ph e as th													
Box	eath certifical attending plant of the set o		d			2							1	75-15
	The law requires that the death ce tale has been signed by the attending age 2 should be detached for us.	Pert II. Other significant condit	ions contributing to de	eath but not resulting	ng in the u	nderlying ca	use giv	en in Pert	l.	23b. Did	tobacco	use contrib	ute to the ca	use of death?
P.0	by the stack									10	Yes 2	□ No 3□	Probably	4 KUnknown
	es that igned b be dete								_					
pic	equires ould be ted by									24e. Wes	en eutopormed?	osy 24	b. Were euto	prior to
ec	hes be								_				completion of death?	n ot cause
H	ysician: The laving sector, page 2 director, page 2 for Be Comp									10	Yes 2	No	1 🗆 Yes	2□ No
ita	certificate rector, pag	25. Wes case referred to medic examiner?	al	,				26. Place	e of Deet	h (Check only	one)			
7	Physician: this certific ral director, TO Be	1 ☐ Yes 2 No	-		/Outpetier	nt 3 DO/	A Oth	ner: 4 N	ursing Ho	me 5 Res	idence	6 ☐ Other (S	Specify)	10.56
Division of Vital Records,	fler the	27. Menner of Death	ing 28a. Dete	ot tnjury th, Dey Year) 28	b. Time o		c. tnjur Wor			28d. Describe	how injur	y occurred		
0	Attending in death.  ector: Afte by the function iffication	2 ☐ Accident Inves	tigetion			M	10	Yes 2						
Ξ	tal or Attending P as a sher death.  al Director: After to the funerated in by the funerated in the funeration:	3 Suicide 6 Could deter	mined 200. Plece	of Injury - At home ing, etc. (Specify)	, ferm, str	reet, fectory,	office			28t. Location ( City or To	(Street en wn, Stete	d Number o	r Aurel Aoute	Number,
0	C Table													
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	(Check only 2 Medica	ing Physician: To the ball Examiner: On the ball	asis of exemination										use(s)
	Within 2 Company	20h Signature and title of partif		ner steted.		200	Linear	a number			20d Det	le signed (14	onth Dev Y	96()
	5 H 3	29b. Signeture and title of certif		3.11		290.	\ 2	e number	75		1 X	Signed (M	onth, Dey, Ye	m()
	N.	- DICE	anu	m)			) 7	000	. )		10	16	00	N. O.
	18:11	30. Name and eddress of perso	who completed caus	se of death (Item 23	(Type,	Print)	2	4.5	1	212	01			
	10	21 Date His different Date	1-11- 51	DA	41/	NOKE	-	/ul						
	State	31. Dete tiled (Month, Dey, Yea	32. F	legistrer's Signeture	9	1.	-							
	Registrar	OCT 1	5 2000	nevera	1	7 1	200	1.0						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death **Physician** of Deeth 4c. County of Deeth 1:00 AM /Medical 4b. City, Town, or Location of Deeth Fecility Name (If not e street and number) Examiner If Under 24 Hrs. 7. Age (In you last birthday) 9. Birtholace (State or Foreign **Funeral** Min 2 F Months Days Hours Director with the Mandand 10a State 10c. City, Town or Location 10d. mside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "--- any injury or other traument— any injury or other traument— 2122 L items 23s 12. Was Decedent Ever in U.S. Armed Forces? 1 DY Yes 2 □ NS 1 ~ 02 ~ 43 If Yes, Give Year or Dates: D1 ~ 05 ~ 46 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indien 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□ Yes 2 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 01-05-46 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. PO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Fether's Name (First, Middle, Last Huisler wrenc 19b. Malling Address (Street and Number or Rural Route Nymber, City or er 20a. Method of Disposition

1. ■ Burial 2 □ Cremetion 3 □ Removal from State 10/4/00 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 9 2627 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one ceuse on each line. Mi) Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner The law requires that the dasth certificats be assecuted Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest director, page 2 should be detached for use as the buriel-tran Due to (or as a co Box 68760 signed by the attending physician P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco was contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yas 2 ☐ No Division of Vital Records, Completed by 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24e. Was an eutopsy performed? aftar death.

Director: Aftar this certificata has I
d in by the funeral director, page 2: 1 Yes 2 BNO 1 ☐ Yes 2 ☐ No I or Attanding Physician: aftar death. 25. Wes case referred to medical examiner? Medical Certification: To Be 26. Place of Deeth (Check only one) 1 Yes 2 No 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 ☑ Netural 2 ☐ Accident 5 Pending Investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital
Within 24 hours a
To the Funeral
Completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steled. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifier

State Registrar

Richard

OCT

31. Dete filed (Month, Dey, Year)

2000

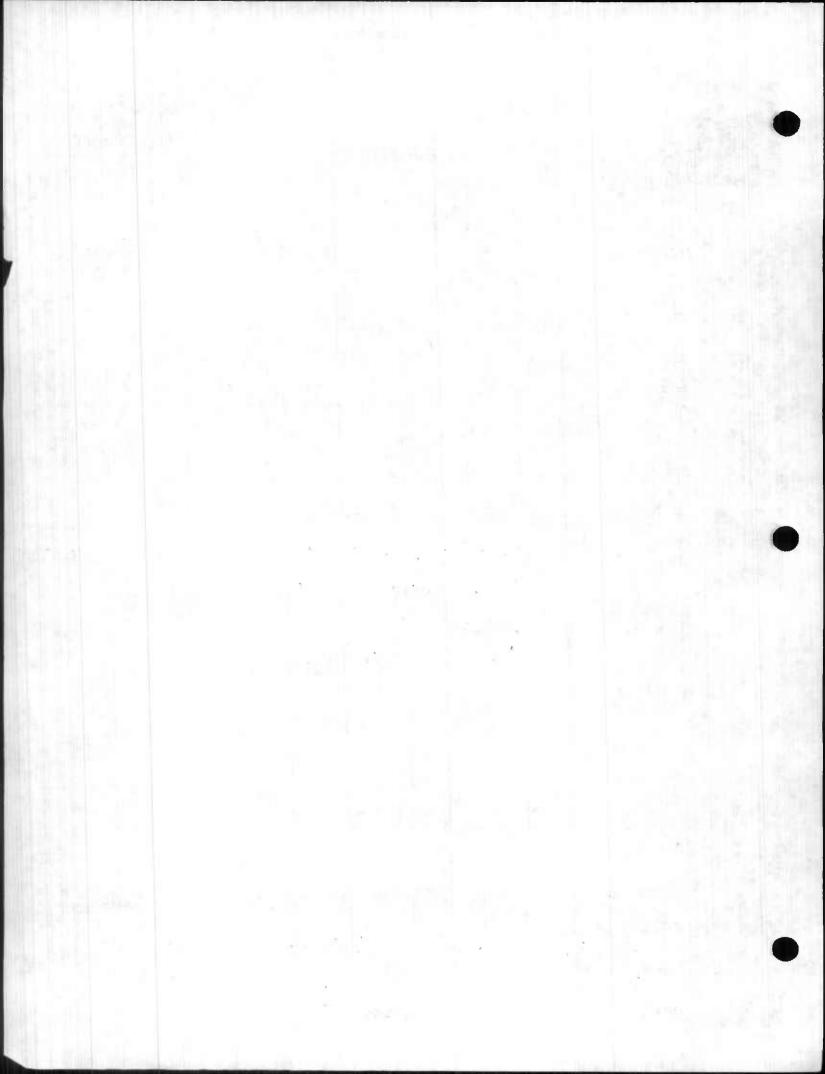
16

**DHMH 16 Rev 6/95** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4660

32. Registrer's Signeture

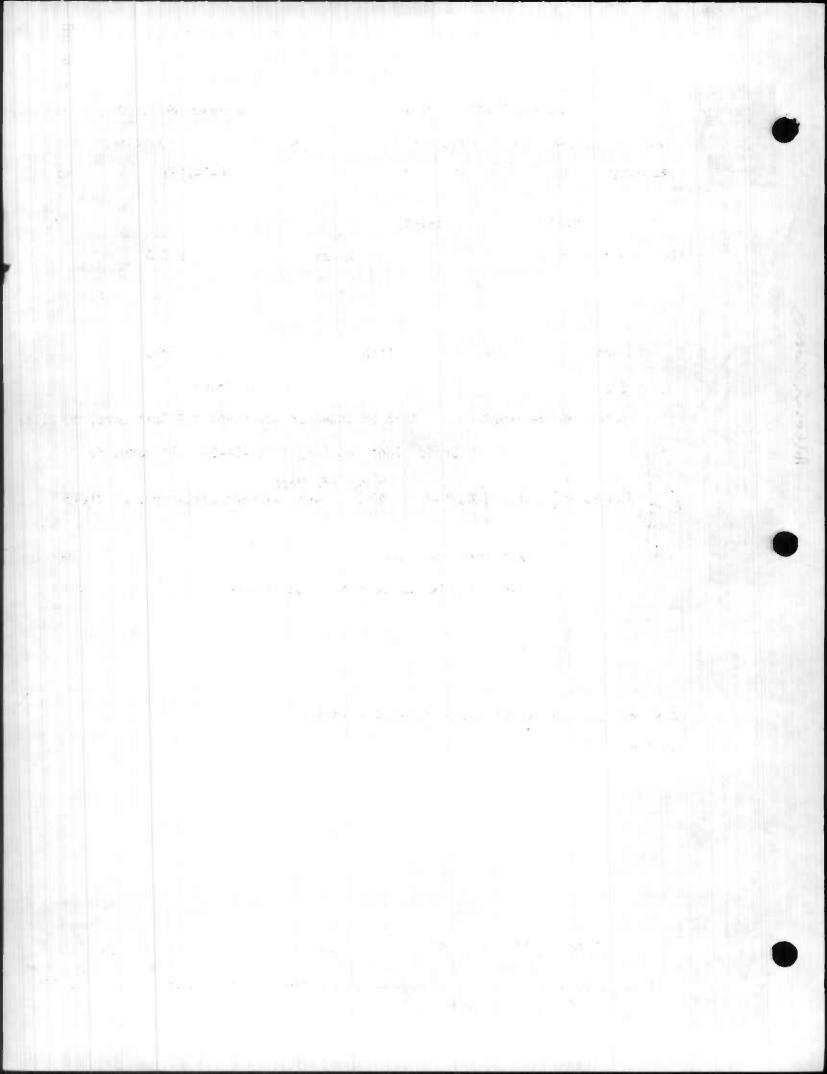


State of Maryland / Department of Health and Mental Hygiene

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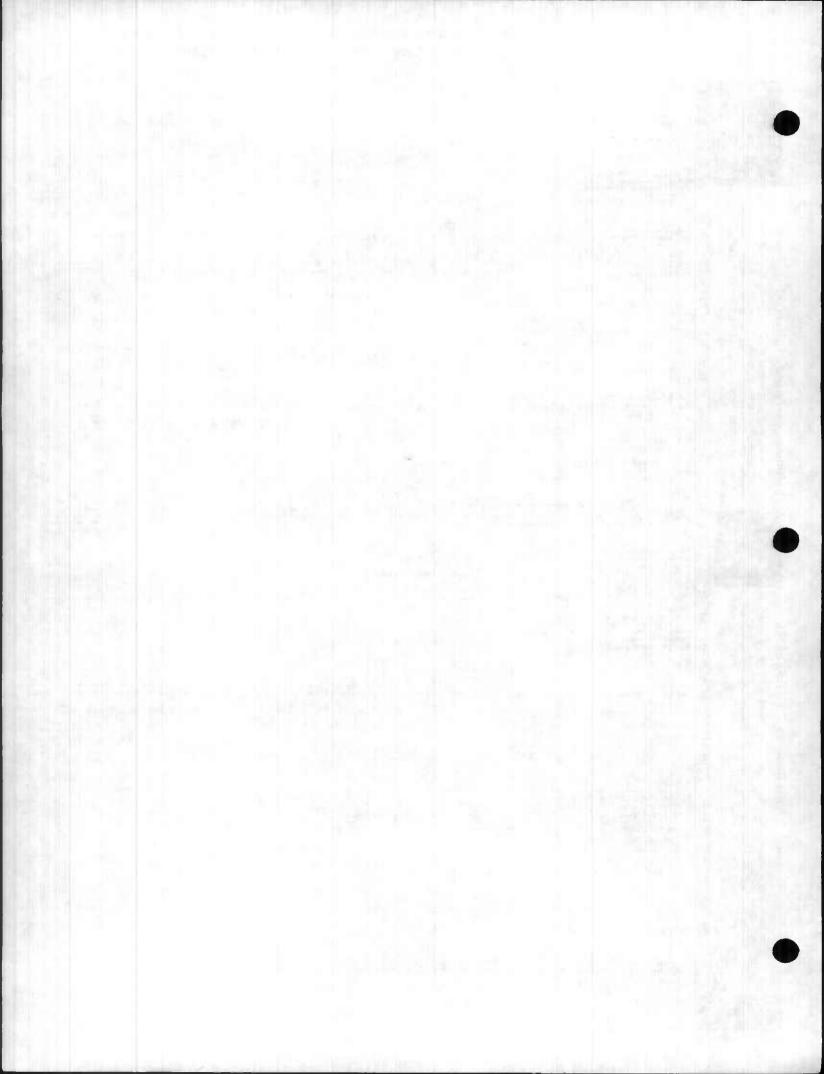
						001	illivai	te of L	Jeani			Reg. No.			
	dent's Name (Firs	t, Middle, La	ist)								2. Date of De			ear 3	Time of Deat
		Adt	rian Ma	arie	Mon	rris					Month Octobe	Day	200		13:19
4a Fecil	lity Name (If not in						17. 4	4	b. City, To		cation of Deat		County of		13.17
				Coultra	Conto	30			Тогла	202		τ.	Balti	more	
	eater Ba		re Medi		(In yrs. last		if Unde	r 1 Year	Tows If Under		8. Date of Bi	rth			(State or Fo
	-30-3398		1 M 2 X F		69	Yrs.	Months	Days	Hours	Min.	(Month, Di	1931-		Country)	(State or Fo
	esidence of Dece	dent		,	09						4-1.	-1931			va
10a. Sta		County			10c. City, T	own or Loc	cation							10d.	Inside City Li
1	Md	Balt			Eco	sex									1 □ Yes 2
10a Str	eet end Number	Dail	.0		ES:	sex	10f. Zip	n Code				10a Citiz	en of Wh	at Country?	
														at Country :	
	Virginia	a Aver	-					21221		1.0.40	7 M	US		Assadasa I	
	itel Status		12. Was Dec Armed F 1 ☐ Yes	cadent Evorces?	ver in U,S.	13. V	Vas Dece Yes, spe	dent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Spe n, Puerto l	cify Yes or No Rican, etc.)	0-		American I White, etc.	noian,
	Never Married 2		If Yes, G	ive		1	☐ Yes	2 X No	Specify:				Specify:	Blac	K
3 1/7	Widowed 4 □ D	ivorced	Year or I	Dates:											
	15. D (Specify on)	ecadent's E	ducation ade completed	)	1	6a. Deced (Give I life. D	ent's Usu	ai Occupe	etion Ju <i>ring</i> mos	t of worki	ng	16b. Kir	nd of Busi	ness/Indust	ry
Eieme	entary/Secondery	(0-12)	College	(1-4or 5+	)	life. D	O NOT u	ise retired	)						
	9th grad	de	N,	/A		T	ech					Sc	hool		
	er's Name (First,	Middle, Last	)						18. Mothe	er's Neme	(First, Middle	, Maiden :	Sumame)		
Jar	mes Brown	n							Sus	ie V	. Brown	n			
19e. Inf	orment's Name/Re						-				l Route Numb	-			
E11	ka Trace	y Perr	y-Daugl	nter		4503	Bri	ghtwa	ater	Cour	t Apt	3 G B	alti	more,	Md 21
	thod of Disposition				20b. Place	of Dispos	sition (Na	me of			Date	20c. Lo	cation - C	ity or Town,	State
	XBuriel 2 ☐ Crer			State	Drui	Rid	ge C	emete	ery	10	-14-00	Balt	imor	e. Md	
	Donation 5 C			-											
21. Sign	of Funeral S	Servica/Lice	nsee	-	1	22	Marc	h F/F	s of Facili	ŧ.					
1	Rime	3 H	This	MDA	n			Waba		Aven	ue Ba	ltimo	re.	Md 21:	215
23a. Pa	. Enter the dise	ease, or con	plications that	caused t	he death. I									Ap	proximate erval Betwee
1	A, or fleat failu	re. List orny	One cause on	earn inte											set end Dea
immedi	ate Cause (Final		no. 11												
	dr condition g in deeth)		a. Puln							_				1	Day
					oue to (or as										
1			b. Pano		itis				c ps	eudoc	yst			i N	leeks
Sequen	tially list condition eading to immedia Enter Underlying Disease or Injury	ns, ate		D	ue to (or es	a conseq	uence of)	:						i	
Sequen if any, le cause. Cause ( that initi	Enter Underlying Disease or Injury	- 2	c											i	
that initi	ated events g in death) Lest			D	ue to (or es	e consequ	ienca of):								
		L	d												
			U												
Part II. C	Other significant of	conditione	contributing to	death but	not resultin	g in the ur	derlying	cause give	en in Part	i.	23b. Did	l tobacco	usa conti	ribute to th	e cause of d
							- 1	c c .			1	Yee 2	⊠ No 3	B ☐ Probab	ly 4 Uni
Bila	ateral pl	Leural	ertusi	ons,	, peri	tone	ar ei	trusi	.on						
											24e. We	s en eutop	sy	24b. Were	eutopsy findi
obes	ity										perl	formed?			ole prior to etion of caus
obes											4.				
											1 🗵	Yes 2	No	1 🔼 Y	es 2 No
25 War	case referred to	medical								e of Death	(Check only	one)			
AYAF	Yes 2 No		Hospital: 1	Inpatien	t 2 ER	/Outpatien	t 3□ D	OA Oth	er: 4 N	ursing Ho	ne 5 🗆 Res	idence 6	3 □Other	(Specify)	
exar		Dandir	28e. Dete (Mo	of Injury	Yeer) 28	b. Time of Injury		28c, Injun Worl	at k?		28d. Describe	how injur	y occurre	d	
exar 1 27. Man	ner of Death	Pending		, _ 0,			М		Yes 2□	No					
10	Natural 5 Accident	investigatio		e of Injur	y - At home	, farm, stre	et, factor	ry, office			281. Location			r or Rural R	oute Number
27. Man 1 💢 2 🗍 3 🗍	Natural 5 Accident Suicide 6	investigation Could not be determined	200. Flac	tine -	LSDBCIIVI						Ony or 10	own, State,	/		
10	Natural 5 Accident	Could not b	200. Flac	ding, etc.	(0)										
1	Natural 5 Accident Suicide 6 Homicide	Could not be determined	build	ding, etc.		dge, death	OCCUFFER	at the tim	ne, date er	nd place	and due to the	cause(s)	and man	ner es stete	d.
1	Natural 5 Accident Suicide 6 Homicide	Could not be determined	build build nyelclan: To th	ing, etc. e best of easis of e	my knowle										
27. Man 1 X 2 3 4 1	Natural 5 Accident Suicide 6 Homicide  ortifier 12 O Note: 1 O Not	Could not be determined	build build nyelclan: To th	fing, etc.	my knowle		estigation	n, In my of	pinion, de			, date end	pleca, en	nd due to the	e ceuse(s)
27. Man 1 X 2 3 3 4 1	Natural 5 Accident Suicide 6 Homicide	Could not be determined	build build nyelclan: To th	ing, etc. e best of easis of e	my knowle		estigation	n, In my op	pinion, dee			, date end 29d. Dat	pleca, en	d due to the	ceuse(s)
27. Man 1 X 2 3 3 4 1	Natural 5 Accident Suicide 6 Homicide  ortifier 12 O Note: 1 O Not	Could not be determined	build build nyelclan: To th	ing, etc. e best of easis of e	my knowle		estigation	n, In my of	pinion, dee			, date end 29d. Dat	pleca, en	nd due to the	ceuse(s)
27. Man 1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Natural 5 Accident Suicide 6 Homicide  ortifier 12 O Note: 1 O Not	Could not be determined	nyelclan: To the miner: On the land mai	e best of pasis of enner state	my knowle examination and.	end/or inv	estigation 29	n, In my op	pinion, dee			29d. Dat	e signed	(Month, Day	ceuse(s)
27. Man 1	Natural 5	Could not be determined	syelclan: To the land man	e best of pasis of enner state	my knowle examination and .	end/or inv	estigation 29 Print)	D27	pinion, dee number 740	eth occurr	ed at the time	29d. Dat Oct 6701	e signed tober	Month, Day 10, Charle	2000
27. Man 1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Natural 5	Could not be determined.  Certifying Production Examples on who Paler	nyelclan: To the miner: On the land mai	e best of pasis of enner state	my knowle examination and .	end/or inv	estigation 29 Print)	D27	pinion, dee number 740	eth occurr	ed at the time	29d. Dat Oct 6701	e signed tober	(Month, Day	ceuse(s)  v. Year)  2000  s Str

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 00 32524

					Certifica	ate of Death	Re	g. No.		
			1. Decedent's Name (First, Middle, Last	)		10	2. Data of Deat		v	3. Time of Death
	Physici		C/AINE			MARROW	OCHOBEA	Day	Yaar 2000	17:39
	/Medic		4a Facility Name (If not/institution, give	sireet and number)			or Location of Death	4c. County of		
7.	Examir	ıer	The House	1 . 111:	x-1/60	# 71	+			
<b> </b>			JOHNS NOPELWS	DAYUTEW /1/K	DICKE CENT	der 1 Year   If Under 24'h	Tmonk		0.0145-1	100 to 10 Feet to 1
п	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	Yrs. Month		lin (Month, Day,	Year)	9. Birthpi	aca (State or Foreign
н	Director		214-36-6133	47	113.		12-9-5	0		MID
	pu ,		Usual Residence of Decedent  10a. State 10b. County	100 Ci	y, Town or Location				41	Del Innido City Limite
	aryta ahon		10a. State 10b. County			2,			1.0	Od. Insida City Limits  1
	W	cto	MD	15	ALTIM	nore				1 2 NO
	4 20	Director	10e. Street and Number		10f. 2	Zip Code	1	ng. Citizan of W	hat Count	try?
	h wil	0 18	6213 ShibVIE	W WAX		2122	4	U.	SA	
	72 hours after deeth with the Manyand natural, or frems 23a or 28a-f ahow dest Examinet must be notified at	Funeral	11. Marital Status	12. Was Decedent Evar in U.	S. 13. Was Dec	cedent of Hispanic Origin? pecify Cuban, Maxican, Pu	(Specify Yes or No-		- America	
0	ter te	E	1 Nevar Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No			ierto Hican, etc.)		, White, e	
21215-0020	Ir. or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □ Yes	2 No Specify:		Specify:	136	ACK
ŏ	"netural",	B	15. Decedent's Edu	ucation	16a. Decedent's Us	sual Occupation		16b. Kind of Bus	siness/Ind	lustry
15	in 72	Completed	(Specify only highest grad	le completed)	(Give kind of the life. DO NOT	work done during most of to use retired)	working			
12	within ene.	E	Elementary/Secondary (0-12)	College (1-4or 5+)		DIAN		MAINZ	27/	ANCE
		Ö	17. Fathar's Name (First, Middla, Last)		CU370		Name (First, Middle, M			
JE .	0 200	Be	A	unna u)		0.1				
Y		2	CLAUDE MIA	KROW			CCA G			
Maryland	d 2 should th end Mer 7 is marks traumatic		19a. Informant's Name/Relationship (T)	rpe, Print)		ess (Street and Number or				
2			GEORGIA MAN	erow	621351	hipvital Wi	BALLIN	WRE M	NI	21224
re	-IE5		20a. Mathod of Disposition		Place of Disposition (A	lame of	Date	20c. Location - 0	City or To	wn, State
Baltimore	Pages nent of int: # ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	removal from State		muracy INC	10-1/0-00	BAITIN	MORI	= mid)
三	교투문을 .		21. Signature of Funeral Service Licens			and Address of Facility				
Ba	mpo mpo my i		1 211 nm	4//	1 W/m	2/16/2010	4571410	WYEN.		- 110/11/2
	40-44		Wille	70well	1300	TIMBE	many	MALL		2017
			23a. Part1. Enter the disease, or composhock, or heart faiture. List only o	ications that caused the death	h. Do not enter tha m	ode of dying, such as care	diac or respireton arri	est,		Approximate Intervat Between
	Physician									Onset and Death
	/Medical		Immediate Cause (Final disease or condition	* THEUMO	14111				:	
ш	Examiner		resulting in death)		or as a consequence of	vf)-				
	1000	ē		000000	n as a consequence c	,,,			1	
	ate be executed Atysician and the burial-trensit	Examiner		b		Α.			1	
	certificate be executed Inding physician and Use as the burfat-trensit	X	Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated avents	Due to (c	or as a consequence of	or);			t	
68760	physician the buria	65	Cause (Disease or injury	Ç					1	
87	cate phys	edicai	resulting In death) Last	Dua to (o	r as a consequance o	f):				
	leath certifical attending pl	2								
Box	th catendarias	an								
	0 0 %	Physician/	Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlying	g cause given in Part I.	23b. Did to	bacco uas con	tribute to	the cause of death?
P.0	by th	Ť					1 U Y	S 2DINO	3 Prot	pably 4 Unknown
								,		
Records,	een sigr	Completed by					24a. Wes e			ere eutopsy findings
8	- 40	et					perform	ned/	COL	ailable prior to mptetion of cause death?
Re	has t							~		
=	E se a						1 🗆 Ye	s 2 No	1 [	]Yes 2□ No
Vital	Physician: The this certificate rel director, pag	Be	25. Was case referred to medicat examiner?	the Mark			Death (Check only on	e)		
of	physic this c	2	1 ☐ Yes Y Z No	Hospitel: 1 Inpatient 2	ER/Outpatient 3□		g Home 5 ☐ Reside	enca 6 □Othe	r (Specify	y)
0			27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe ho	w injury occurre	be	
0	Attending r death ector: Alle by the tune	atic	↑ Natural 5 Pending 2 Accident investigation	(110.11.1, 2.1)	M	1 ☐ Yes 2 ☐ No				
/is	Attendi r death ector: by the f	Hic	3 Suicida 6 Could not be determined	28e. Placa of Injury - At he	ome, farm, street, fact	tory, office	28f. Location (Si		er or Rura	/ Route Number,
=	2442	Certification:	4 Homicide	building, etc. (Specif	y)		City or Town	n, State)		
	Hospital		29a. Certifier 1€ Certifying Phy	sician: To the best of my kno	wiedne death occurr	ad at the time, date and of	ace, and due to the o	use(s) and ma	nner as si	tated
	545 P	edical	(Check only 2 Medical Exami	ner: On the basis of examine and manner statad.	tion end/or investigati	on, in my opinion, deeth o	ccurred at the time, d	ete and place, a	nd due to	the cause(s)
	To the	Me	29b. Signature and title of certifier	und mainor statau.		29c. License number	2	9d. Date signed	(Month	Day, Year)
	F 3 + 8/	1	A A	1.0		71007		1	4	1 -
	h.		way,	mo		21007		OBER	_ //,	2000
	14	1	30. Name and address of person/who or	ompleted cause of death (Item	n 23a) (Pype, Brint)	1	> 14	A.	1.	Tet.
	VV	1	Welson Hun	3 MD. 4706	+ KASTERN	STYRAUR F	SUSMOLK	- MALV	AUS	21224
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature			1		,
	Registr		OOT 1 6	non barre	w 19	has it				



		State of Ma	ryland / Dep Ce	ertificate of		d Mental Hy	Reg. No.	32525
Physician	1. Decedent's Name (First, Middla, L					2. Dete of De Month	eeth Dey Ye	3. Time of Deeth
/Medical		Robert Madd	on .				12, 2000	2 pm
Examiner	4a Facility Name (If not institution, g					or Location of Deat		
		ey Court Sex 7. Age	(In yrs. lest birthda	u) If Under 1 Yea	Reister	rs. 8 Date of Bi		Ltimore Birtholace (State or Foreign
uneral irector	216-54-4832	1 <b>X</b> M 2□ F	49 Yrs.	Months Dey	s Hours N	lin. (Month, De	28, 1951 I	Birthplace (Steta or Foraig Country)
	Usuel Residence of Decedent							
Institution, or frome 23s or 23s-1 show edical Examinat must be notified at letted by Funeral Director	10a. Stata 10b. County  Md. Baltimos		10c. City, Town or	erstown				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
otifie ecto			Keist				10a Citizen of Miles	
Dir	10e. Street and Number  5 Staley (	Tours		10f. Zip Code	21136		10g. Citizan of What	
ricer must be noutled Funeral Director	11. Marital Status	12. Wes Decedent E	ver in U.S. 13			? (Specify Yes or No uerto Rican, etc.)	U.S. 0- 14. Race - /	American Indian,
by Fur	1 Never Married 2 Merried 3 Widowed 4 Divorced	Armed Forces?  Valves 2 □ N If Yes, Giva Year or Dates:	· 1971 -	If Yes, specify Cu 1 ☐ Yes 2 ☐ N		uerto Rican, etc.)	Specify:	White, etc.
pe	15. Decedent's	Education	16a. Dec	cedent's Usual Occ ve kind of work don	supation	warking	16b. Kind of Busine	ess/Industry
once. To Be Comple	(Specify only highest g Elamantary/Secpredary (0-12)	College (1-4or 5	life	. DO NOT use reti	red)	WOTKING	H C Co.	ast Guard
Be Completed	10 E. A.		D	iesel Med		None /First Afields		ast waard
To Be	17. Father's Name (First, Middle, Las Richard					Catherine	Hepple	
	19a. Informant's Name/Relationship <b>Relen Madden</b>		The second second second				ber, City or Town, Sta Md. 21136	te, Zip Code)
	20a. Method of Disposition		20b. Place of Dis	position (Neme of remetory or other p	olaca)	Data	20c. Location - City	or Town, State
	1 ☐ Burial 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spec					Oct. 16.	2000 Owing	s Mills, Md.
Duce	21. Signature of Funeral Service Lic	ensee		22. Nama end Add	ress of Facility			21117
3	1 4.4. Sele	liaidt		11605	Reister	ral Chape stown Rd.	Owings Narrast,	
4	23a. Perri. Enter the diseese, or co shock, or heart failure. List on	mplications that causad y one causa on each lin	the death. Do not e	enter the moda of d	lying, such as car	diac or respiratory	arrast,	intarval Batween
ו	V							Onset end Death
	Immediate Causa (Final disaasa or condition resulting in death)		tingto.		Disea	130		15 years
٥			Due to (or es a cons	saquence of):				
Examiner	Sequentially list conditions	b	Due to (or as a cons	sequence of):				
Exe	Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying							
dicai	Cause (Disease or injury that Initiated events resulting in death) Lest	c	Due to (or es a cons	equenca of):			Dell'	
Mec		l d						
lan							H	
Physician/Med	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying ceuse	given in Part I.			bute to the cause of death
						_ 1	Yes 2 46 3	☐ Probably 4 ☐ Unknow
od by								4b. Wara autopsy findings available prior to
Completed						- per	ormed?	completion of cause of death?
oml						10	Yes 2000	1 □ Yes 2 No
Bec	25. Wes case referred to medical				26. Place of	Death (Chack only	one)	
To	examiner? 1 Yes 2 No	Hospital: 1 Inpatia		IENT 3LI DOA		ng Home 5 12 Res	sidence 6 Othar (	Specify)
	27. Menner of Deeth  1 Staturet 5 Pending	28e. Dete of Injur (Month, Day	Year) 28b. Time	/ V		28d. Describe	how injury occurred	
Certification:	2 Accident invastigat 3 Suicide 6 Could not	be One Blace of Init	ry - At home, farm,		Yes 2 No	28f. Location	(Street and Number of	or Rurel Route Number,
ertif	4 ☐ Homicide datarmine	building, ato	. (Specify)	Street, lectory, ont			own, Stata)	, , , , , , , , , , , , , , , , , , , ,
edical C		Physician: To the best of aminer: On the basis of and mannar sta	examination and/or					
N N	29b. Signature and title of certifier	1	0	29c. Lice	ansa number	1	29d. Date signed (A	Month, Dey, Year)
	1	Y	1/M	DA	4052	6	10/13	12000
	30. Neme end address of person wh	o complated ceuse of de	eath (Item 23e) (Typ	e, Print)			10/62	-//
	A DAM	ROSENI	3LATT	m. Di	John	HONG	~) Ito:	p.tal
State	31. Date filed (Month, Dey, Year)	32. Registre	r's Signature	, ,				1

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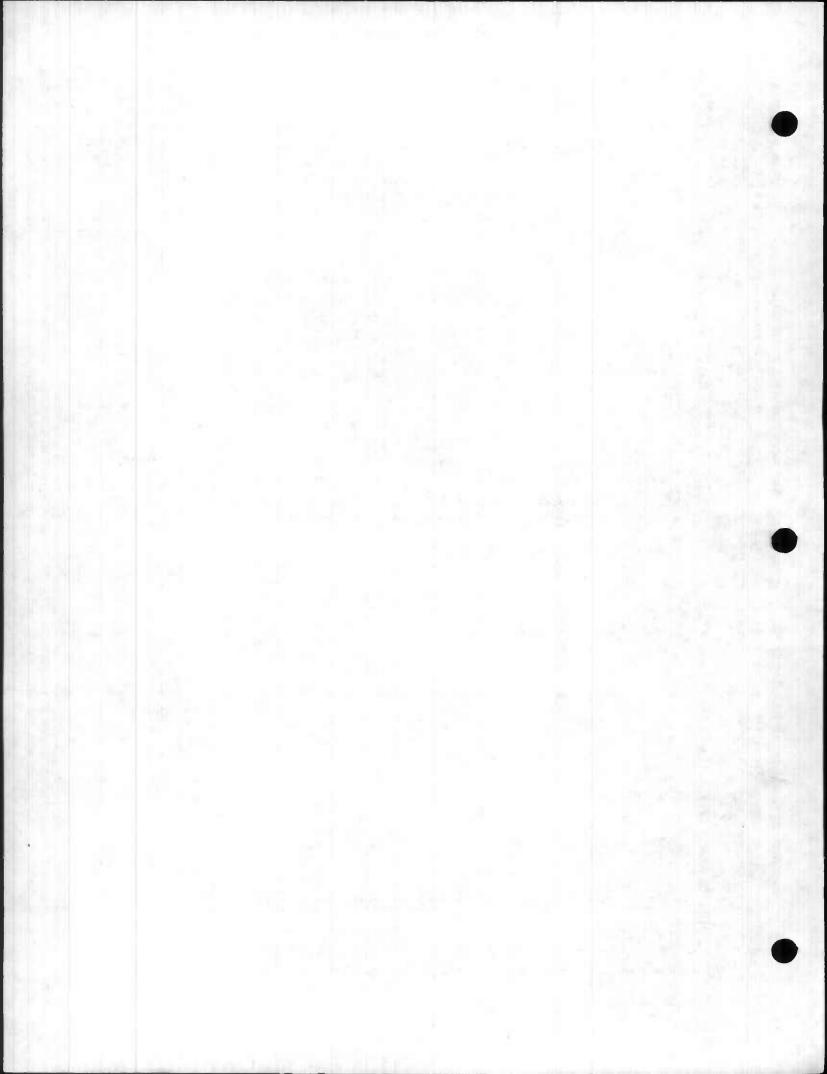
Tire has taunt on ic., where Elle, ic.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** ANN CHRISTOPHER MARTIN October 9, 2000 12:41PM /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 16 Country CLub Lane Phoenix Baltimore, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year)
July 12, 1 Birthplaca (State or Foreign Country) **Funeral** 1□M 2□F Months Days Hours Min Yrs. 74 1926 Tennessee 213-32-2603 Director Usual Residence of Decedent 10c. City. Town or Location 10a, Stete 10b. County 10d, Inside City Limits flem 27 le marked other than "natural", or flema 23a or 28a-f ahow other traumatic event, the Medical Examiner must be notified as 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 16 Country CLub Lane 21131 USA Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indien. e filed within 72 hours efter al Hygiene. other than "netural", or ite 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) 5+ Hospital Nurse 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) permit. Peges 1 and 2 should be fit.
Department of Health and Mental th,
Important: if flem 27 le marked oth
eny linjury or other traumatic evenpace. Daniel McCall Christopher Gladys Daisy Duffer 19a. Informent's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Kenneth C Martin Husband 16 Country CLub Lane Phoenix, Maryland 21131 20b. Plece of Disposition (Nema of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 Burial XXCremetion 3 Removel from State
4 Donation 5 Other (Specify) Greenmount Cemetery 10-10-00 Baltimore, Maryland 21. Signeture of Funeral Service Licent 22. Name end Address of Fecility Mitchell-Wiedefeld Funeral Home Inc. nnes 6500 York Road Baltimore, Maryland 21212 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line. Approximete Intervel Between Onsat and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical one hon-Micoralda Examiner Examiner 11. my Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last the attending physician hed for use as the buria Box 68760 Physician/Medical Due to (or es e consequence of): P.0. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? signed by I 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy 1 Yes 2 No 1 Yes 2 No or Attending Physicien: after death. Director: After this certifica 25. Wes case referred to medical axaminer? 8 26. Piace of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residenca 6 ☐ Other (Specify) 1□ Yes 28 No 2 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 1 Waturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Vithin 34 hours at To the Funeral D 15. Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and menner steted. edical 29a. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier 037016 Attendin October 10, 2000 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) Kenneth Green 6701 North Charles Street Towson MD 21204 Suite 4105 31. Date filed (Month 32. Registrer's Signature State 2000 Registrar

DHMH 16 Rev 6/95

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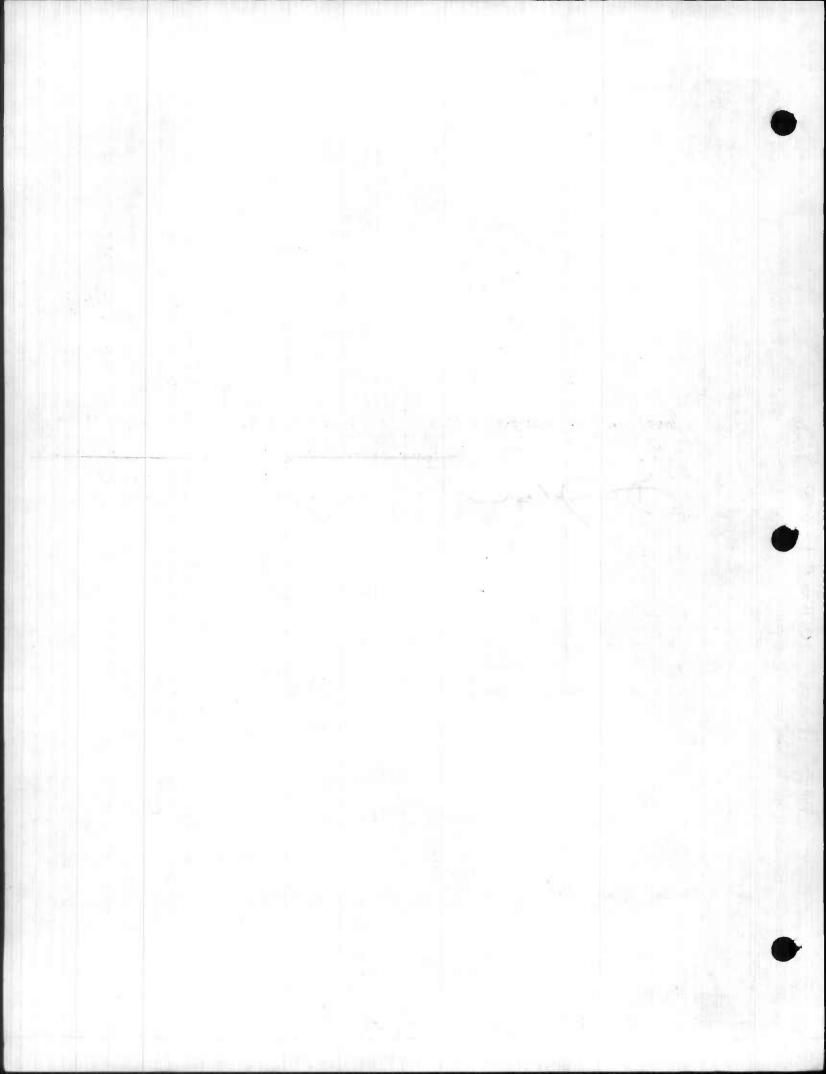
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Physicia (Media	_	James Le								r 15, 200	
/Medic Examine	_	Joseph R			ber)			4b. City, Town, or L Balt	ocation of Death	4c. County of Do	
Funeral Director		5. Social Security N	035	Sex 7	. Age (In yrs.		If Under t Year Months Days		8. Date of Birth (Month, Day Jan 26	, 1956 9.E	Birthplece (State or Foreign Country) Maryland
the Maryland 28a-f ehow		Usuel Residence of 10a. Stata MD	10b. County	1	10c. City	y, Town or Loc	Baltim	ore			10d. Inside City Limits 11 Yes 2 □ No
death with the Maryland ms 23a or 28s-f show	Funeral Director	10e. Street and Nur 529 Bris		ad			10f. Zip Code	21229	1	0g. Citizen of Whet	Country?
020 urs after ir, or its	P	11. Meritel Stetus  1 Never Merri 3 Widowed	ed <b>3</b> Merried	12. Wes Deced Armed Force t  Yes 2 If Yes, Give Year or Date	es?		Vas Decedent of I Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Ai Bleck, W Specify:	merican Indien, hita, etc. Black
within within then.	Completed	(Spec Elementary/Seco 12th		ducation rade completed) College (1-4	lor 5+)	(Give I	ent's Usuel Occup kind of work done OO NOT use retire Paint	during most of world)	king	16b. Kind of Busine:	ss/Industry  IDPOVEMENT
	Bec	17. Fether's Name		1)				T	na (First, Middle, I		
Maryiand d 2 should be flie th and Mental Hy 7 is marked othe traumatic event	2	James Ro	ss McCoy	7				Sara	h Mae Wi	lliams	
10 = = 3		19e. Informant's Ne	and the same of th		(TT) C			t and Number or Ru			
Heelt Heelt om 27	+	Brenda I 20a. Method of Disp		L-Jackson		-	9 Brisba sition (Name of	ne Road E			
Baltimore, M permit. Peges 1 and 2 Department of Heelth is Important: If Item 27 is any injury or other tra		1 Burial 2 Donetion	Cremetion 3 [ 5 Other (Special	.,	eto C	butus	Memorial CEMETERY	Park 10	. 1	Ansbowne MA Arbutus,	
Baltim pemit. Pe Departmen Important: any Injury		21. Signeture of Fu	Da Ja	Ryl		5		er Avenue	Baltimo		ice Land 21215
Physician /Medical		23a. Part1. Enter the shock, or head in the shock of head in the shock of the shock	Finel	nolications that cause on eed		, , ,		ing, such es cardiac	or respiratory em	est,	Approximeta Interval Between Onset and Death
Examiner		resulting in death)		· 1 4 0 !		r es a consequ	urun on uence of):	na wing			1 6/00
D is				b	Brein	netac	480		MALE OF		i
876(	edical Examiner	Sequentially list cor if any, leading to im causa. Entar Unde Cause (Disease or that initiated events resulting in death) l	nditions, mediata rhying injury	с.		r as a consequ					1
5 0 6				d							
deeth cert deeth cert de ettendin d for use	Cla	Part II. Other signifi	cant conditions	contribution to deal	th but not resu	ulting in the un	derlying cause of	ven in Part I	23h Did to	hacco usa contribu	ute to the cause of death?
S, P.O. ss that the gned by the	by Physician/M					July III the bil	donying cause gr	VOITETT OILT.	05%		Probably 4 Unknow
Records, P.O. Box he law requires that the deeth cer e has been signed by the ettendin ege 2 should be detached for use	Completed								24a. Was a perform		b. Wera eutopsy findings available prior to completion of cause of death?
The it	် ပ					11114			1□ Ya	as 2DNo	1 ☐ Yes 2 ☐ No
- 05	10	25. Was case reterr examiner?		Hospitel:			0t	hor	th (Check only on		Hosmice
on of ding Physics.  After this funerel di	tion: To	1 Yes 2  27. Manner of Death  Netural  2 Accident		28a. Data of (Month,		28b. Time of Injury	28c. Inju	4 LI Nursing H	ome 5 ☐ Reside 28d. Describe ho	ow injury occurred	specify)
DÍVÍSÍON al or Attending s effer death. I Director: After	Certification:	3 ☐ Suicide 4 ☐ Homicida	6 Could not l detarmined	289. Place of	I Injury - At ho , etc. (Specify		et, factory, office		28f. Location (St City or Town	reet and Number or n, State)	Rural Route Number,
		29e. Cartifier (Check only one)	Certifying P	hysician: To the be miner: On the basi and manne	is of examinat	wledge, death ion and/or inv	occurred at the ti estigation, in my o	me, date end place, opinion, deeth occur	, and due to the corred at the time, do	ause(s) and menner ata and place, and c	es stated. dua to the cause(s)
To the To the Comp	-	29b. Signature end	itle of certifier	.1			29c. Licens	se number	2	9d. Date signed (Mo	onth, Day, Year)
(1/		Har	anne o	JAMES S	n M	0.	Da	035712		(0/15/10)	
30	)	Name and addre	ss of person who	completed causa	of death (Item	23a) (Type, F	Print) Suk	red Pl.	Balton	Up. 21%	2/
State		31. Date filed (Mont	h, Day, Year) -	32. Reg	pistrar's Signa	ture &	7	•			4
Registra	r	00	T 1 8 20	00	Last Value	11	DOON	2			

DHMH 16 Rev 6/95

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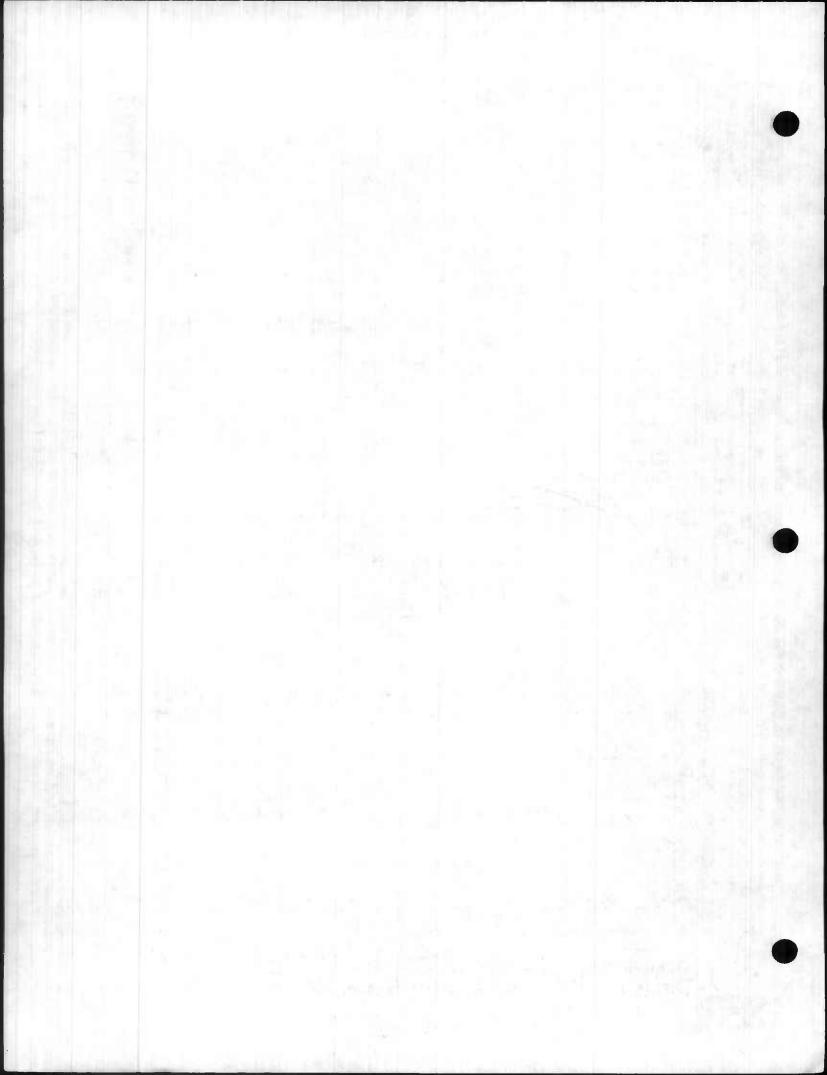
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State of Maryland / Department of Health and Mental Hygiene 00 32529

		Certificate of	Death	Red	g. No.	02020
Physicia: /Medica				2. Dete of Death		3. Time of Death 11:15 p.m
Examine	An English blome office the state of the sta	"C"	4b. City, Town, or Le Essex	ocation of Death	4c. County of De Baltimo	
Funeral Director	5. Social Security Number 224–22–8110 8. Sex 1 M 22 F 80	Ast birthday) If Under 1 Year Months Days		8. Data of Birth (Month, Day, 1) FeD. 7,	1920 Vi	Birthplaca (Stata or Foraign Country) rginia
a Maryland la-f show fiffed at		y, Town or Location				10d. inside City Limits 1 ☐ Yas 2☒ No
eath with the Maryla is 23s or 28s-f shor must be notified at	10a. Street and Number 810 Briarhill Place, Apartment	10f. Zip Code 21221		10	g. Citizen of What U.S.A.	Country?
urs after d al', or ther Examiner,	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Yeer or Dates:	S. 13. Was Decedent of If Yes, specify Cul	oan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, W	merican indien, Thite, etc. White
ad within 72 ho yglene. wr than "natur f, the Medical	15. Decedent's Education (Specify only highast grada complated)	16a. Decedent's Usuel Occu (Giva kind of work done life. DO NOT use retin	during most of work	ing	6b. Kind of Busines	ss/Industry
jene. jene. r than	Elementary/Secondery (0-12) College (1-4or 5+)	Homemaker	<i>30)</i>	C	own Home	
d 2 should be filed thank Mental Hyg 7 is merked other traumetic event,	17. Fathar's Nama (First, Middla, Last)			e (First, Middle, Mi lizabeth		
and 2 sho alth and 1 27 is me or treams	19a. informant's Name/Relationship (Type, Print)  Clayton James Reynolds (husband	19b. Mailing Address <i>(Stree</i> d) 810 Briarhi				
mit. Pages 1 i partment of He portant: If Item y Injury or othy SB.	1 ABurial 2 Cremation 3 Removal from State	lace of Disposition (Name of emetery, crematory or other place)  1y Hill Mem. G			Oc. Location - City  Baltimo	or Town, State ore, Maryland
permit. Departr Importa any inju	21. Signature of Fundal Service Licensee		ess of Facility UZdZisnki			A. ryland 21221
Physician /Medical Examiner	23a Part Enter the disease, or complications that caused the death shock, or neutralities. List only one ceuse on each fine.  Immediate Cause (Final disease or condition resulting in death)	fas a consequence of):	fa.l.	v		Interval Between Onset and Death
certificate be executed tring physician and use as the bunal-transit	Cause (Disease or Injury that initiated events resulting In death) Last	r as a consequence of): r as a consequence of):				0
the atter	Part II. Other signiffcant conditions contributing to death but not resu	ulting in the underlying cause g	iven in Part I.	23b. Did tob		ute to the cause of death
				1  Ye	• 2€M6 3□	Probably 4 Unknow
aw requisite particular section 2 should				24a. Was an perform		b. Were autopsy findings available prior to completion of cause of death?
Fad			1,000	1 ☐ Yes	s 2 No	1 ☐ Yas 2 ☐ No
Physician: The this certificate ral director, pag		500	ther:	th (Check only one		
this h		28b. Time of Injury W	4 LI Nursing H	28d. Dascribe hov		респу)
Defe	3 Suicide 6 Could not be determined 28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, fectory, office		28f. Location (Str. City or Town,		r Rural Route Number,
Hosp 24 hour Funer stely fil						
Toth		29c. Licer	ise number	29	d. Date signed (M	onth, Day, Year)
1/2	30. Name and address of person who completed cause of death (Item	1 23a) (Type, Print)	15408	3	10/16/	00
State	31. Date filed (Month, Day, Year)  32. Registrar's Signal  OCT 1 6 2000	801 HUDSON	ST BA	10 M.	0 212	24
Registra	OCT 1 6 2000 Commen	D Doork				

ORIGINAL



address of person who completed cause of death (flem 23a) (Type, Print)

LYCOIA OND

32. Registrar's Signature

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 1 Yes 2 No 1 TYes 2 No Other: 4 Nursing Home 5 Residence 8 Dother (Specify) HOS 100 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 1 Cortifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted. 29d. Data signed (Month, Day, Year)

3. Time of Deeth

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximete Intervel Between Onset and Death

snou /Z

YY Yes 2 No

MARYLAND

Bleck, White, etc.

State Registrar

29a. Certifier

(Check only one)

31. Date filed (Month.

29b. Signature and title of certifie

C

16

2000

Dey, Year)

**DHMH 16 Rev 6/95** 

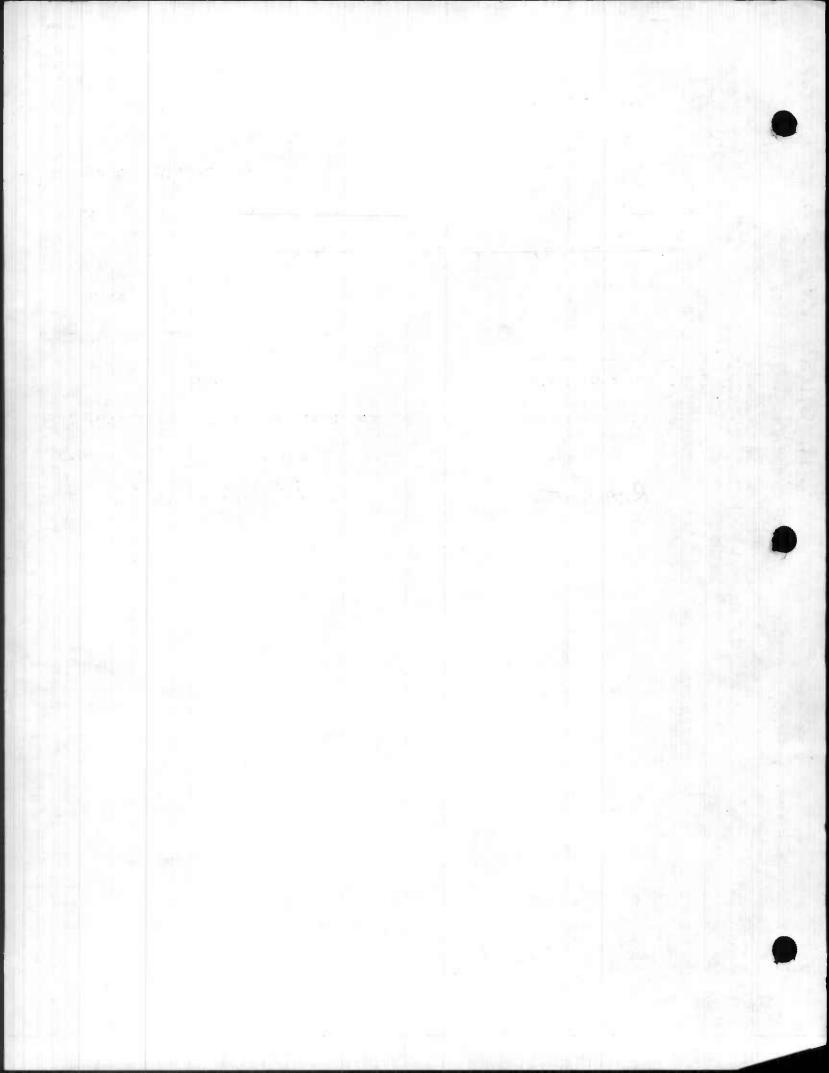
• Hospital 24 hours a • Funeral

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To the Fund

29c. License number

828 N. EulawSt.



ian	1 December 1 Alan	me (First, Midd	do lest					Death	2. Dete of De	Reg. No.		3. Time of Deat
ical	1. Decedent a Na/		gie Jos	sephi	ne Rup	pert			Month	12, 2000	Year	3:30
ner	4e Fecility Neme		on, give street			ıg		4b. City, Town, or Catonsv			of Deeth	
	5. Social Sacurity <b>216-56-9</b>		6. Sax		Age (In yrs.	lest birthday) Yrs.	if Under 1 Year Months Days	if Undar 24 Hrs Hours Min.	(Month, D	rth ey. Year) 20, 190	9. Birthpl Count 7 Ma	lece (Stete or Fore try) ryland
	Usuel Residence	ot Decedent	v		10c Cit	y, Town or Lo	ocation					0d. Inside City Lin
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Director	10e. Street end No	THE STATE OF					10f. Zip Code			10g. Citizen of 1	Whet Coun	itry?
al D	47	731 Old	Court	Rd.			21208			U.S	.A.	
by Funeral	11. Marital Stetus 1 □ Naver Mar 3 🏋 Widowed	rried 2 Me	rried 1 (	as Decedermed Force  Yes 2.  Yes, Give ear or Dete	No No		Was Decedant of Hill Yes, specify Cub		Specify Yes or N to Rican, etc.)	Ble	ca - Amaric ck, White, o	etc.
	(Spe	15. Decede	nt's Education			(Give	dent's Usual Occup	during most of wo.	rking	16b. Kind of B	usiness/Ind	dustry
non-dimon	Elementery/Sec			ollege (1-4	or 5+)	life.	DO NOT usa ratire <b>Housewi</b>	d)		Hom	emake	r
	17. Fathar's Name	e (First, Middla	, Last)			1			ma (First, Middle	a, Maiden Sumen		
1		Robert		er Sp	echt				ie Breng			
2	19a. Informant's N	Name/Relation	ship (Type, Pi	rint)			ng Address (Street					
	Diane	Carol	Rupper	t - G	randda	anghter	43 Ceda	rhill Rd	., Randa	allstown	, Md.	21133
		isposition 2 Cremation 5 Other (		al from Sta		cemetery, crei	osition (Neme of metory or other pla	m. Oct.	Date 14,2000	20c. Location - Randall		
	resulting in deeth	tion i)	a		Due to	ve i	reaut	failure	2 .		1	
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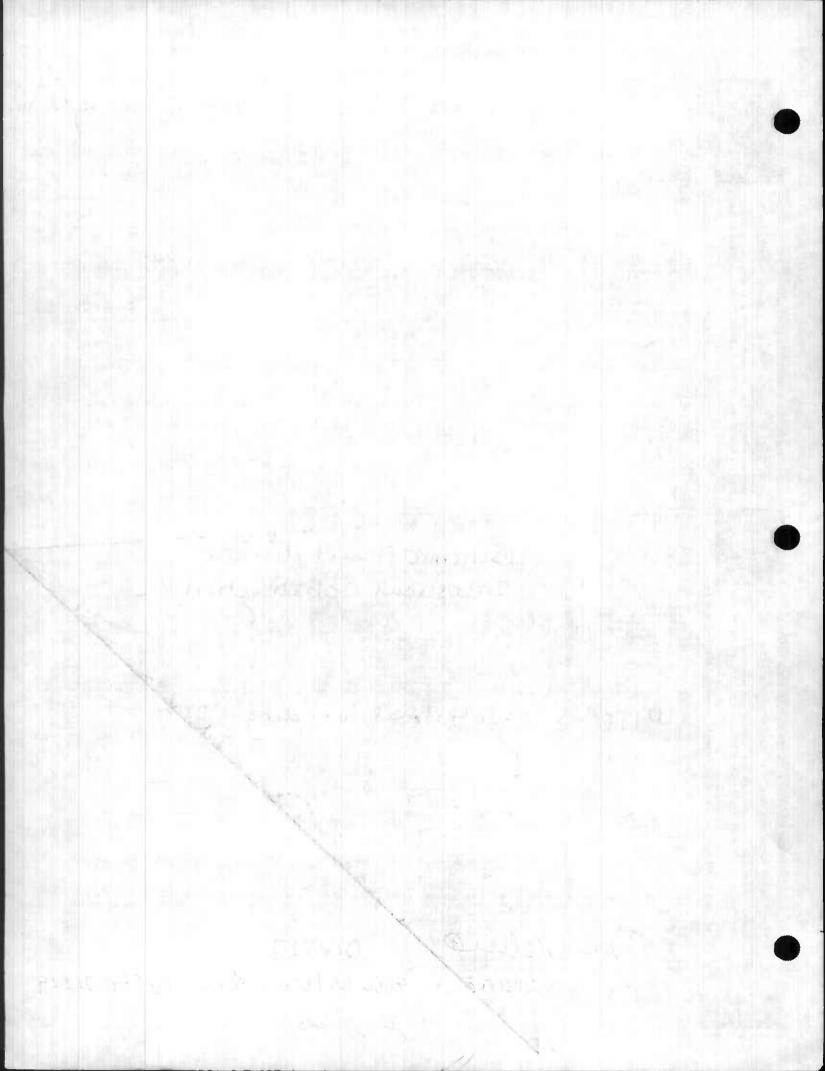
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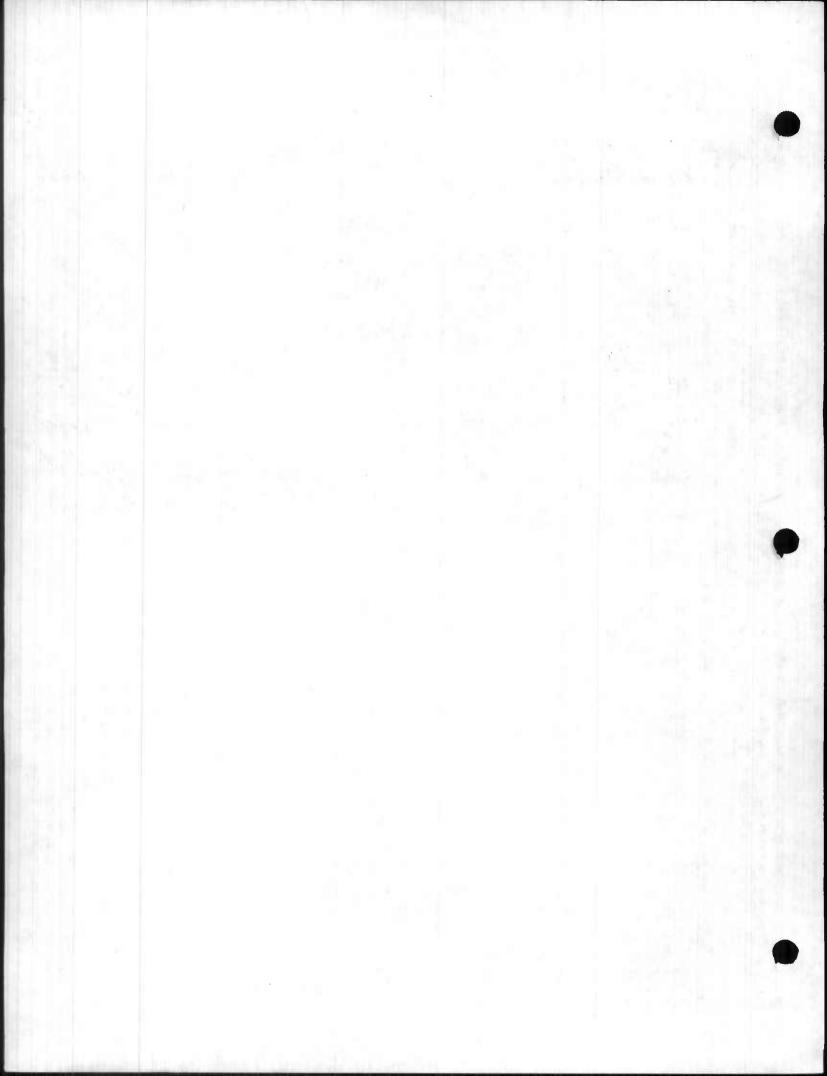
State of Maryland / Department of Health and Mental Hygiene

				Otato of In	ary land / L	Certificate	of Death	F	leg. No.	3	2531
			1. Decedent's Name (First, Middla, Li	est)				2. Data of Dea	th	V	3. Tima of Death
	Physicia /Medic		James	Sauve	ders			Month 10	12 2	Year	06:30 An
	Examin	-	4a Facility Nama (If not institution, gir	va street and number)		Printed to se	4b. City, Town, or I	Location of Death	4c. County	of Death	
		•	Bon Secour				Baltimo	RP	NA	7	
	Funeral		5. Social Security Number 6.		a (In yrs. last bir	thday) If Under 1 Y	aar If Undar 24 Hrs. ays Hours Min.	8. Deta of Birth (Month, Day	Voorl	9. Birthpl	aca (Stata or Foreign
	Director		238-24-6039	10XM 2□ F	87	Yrs. Mornins D	ays Hours Mill.	5-10		North	Carolina
	p .		Usual Rasidance of Decedent								
	arylar and and		10a. Stata 10b. County		10c. City, Town	n or Location				10	Od. Insida City Limits
	W P	5	MD	IA	BALT	IMORE					Yas 2□ No
	\$ 9 E	Sir o	10e. Street and Number			10f. Zip Co	da		Iog. Citizan of W	hat Count	iny?
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5	72 l	Be Completed	15. Decedent's E (Specify only highest gr		16a.	Decedant's Usual O (Giva kind of work of	ccupation UNK ona during most of wor stired)	rking	16b. Kind of Bu	sinass/Ind	lustry VIVKNEWN
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	il Hygiene. other than	ပိ	17. Fathar'e Nama (First, Middla, Lasi	n LINK Almush			10 Mathada Mar	me (First, Middla,	Maidea Cumen	al walk I	N/ v A/
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Maryland	12 st		19a. Informent's Neme/Ralationship	-1/			reet and Number or Ru				
	other tr		Carla Kamson / L 20a. Mayhod of Disposition	egal Guard	12h 34	Disposition (Nama		300. B.711			
0	Pages nent of H int: If Ha		1. Burial 2 Cramation 3	Removal from State	cemeter	ry, crematory or otha	placa)		20c. Location -	City or Tov	MI, Stata
Ë	tant:		4 □ Donation 5 □ Othar (Speci	**	Mt. Zi		-	10-14-00	Lansdow	ne, 1	MD
Baltimore	permit. Pages 1 and 2 should be flied within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic avant, in a single.		21. Signature of Funeral Service Lice	nsee		22. Nama and A	ddréss of Facility				
	707 9 Q		1110	11/1/20		WYLIE FUNE	RAL HOME PA 6	SEN.GILMON	ST. BALTI	MOPE.	4021217
			23a. Part V Entar tha diseasa, or conshock, or haart failure. List only	plications that causac	tha daath. Do r	not antar tha moda o	dying, such es cardiac	c or raspiretory er	ast,		Approximata Intarval Batween
	Physician										Onsat and Daath
	/Medical		fmmediate Causa (Final disaasa or condition	TSC	home	hou	vel dis	ease.			
	Examiner		resulting in deeth)	8	Due to (or as e	consequence of):	O(,S				
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/	and trans	Eas	Sequentially fist conditions,	U	Dua to (or es a	consequence of):					
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<u>.</u>	e de de hed f	/slc	Part If. Other significant conditions	contributing to death b	ut not rasulting in	tha undarlying ceus	a givan in Part I.	23b. Did to	obacco uae cor	tribute to	the cause of death?
P.O.	d by detac		Ilpner a	00 / CO 14	Loit	sal h	leeder	101	20 No	3 Prob	bably 4 Unknown
Ś	tres tr	Completed by	779	011.017	11-03	(, 40)	1 cc acr	"			
Records,	inpe sen s	ted						24a. Was a perfor		ava	are autopsy findings allabla prior to
O		ple									nplation of causa death?
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Viital	lan: ntific ctor,	Be	25. Was case referred to medical axaminar?				26. Place of Dec	eth (Check only or	ne)		
2	nis ce dire	To	1 Yas 20 No	Hospital:	nt 2 ER/Ou	tpatient 3 DOA	Othar: 4 Nursing H	łoma 5 ☐ Rasid	ance 6 Othe	er (Specify	0
0	nera There	ü	27. Mennar of Death  1 Dending  5 Pending	28a. Dete of Inju (Month, De	ry (28b. 7	Firme of 28c.	injury at Work?	28d. Dascribe h	ow injury occurr	ed	DIE PERS
0	andfire path.	ati	2 ☐ Accident invastigation			М	1 ☐ Yas 2 ☐ No				
Division of	re Att	Certification:	3 Suicida 6 Could not be determined	28a. Place of Injusting, at	ury - At home, fa	rm, siraat, factory, of	fice	28f. Location (S City or Tow		er or Rural	I Routa Number,
0	led in bell										
	tosp t hou uner	edicai	(Check only 2 Medical Example 12				na tima, data and place my opinion, deeth occu				
	To the Hospital or Attanding Physician: The law within 24 bours after death, within 24 bours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Med	one)	and mannar sta	ated.						
	5 1 × 5 0	-	29b. Signatura and titla of certifier	Ye 0.	. 0		canse number		29d. Date signed	(Month, L	Jey, Year)
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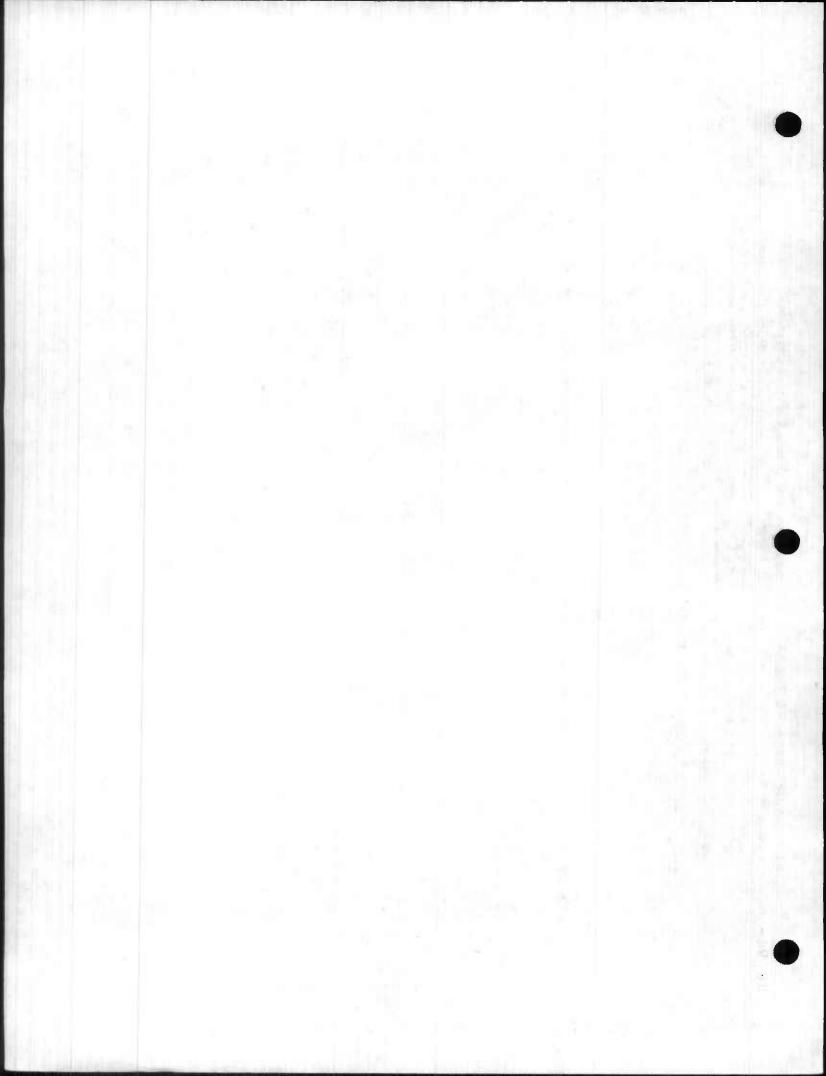


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Smith end item 2	23a,27 per me G788 10/1				Reg. No.	0 32332				
Physician		<u> </u>	2		Dete of Deeth Month Day	3. Time of Death 200 11:10 A.M.				
/Medical	4e Facility Neme (Il not institution, gir	ve street and number)	1)							
Examine	Johns Hopkins Ho	ospital	s - morella	Baltimore		N/A				
Funeral Director	218-60-5364		birthdey)   ff Under 1 Yeer   Months   Deys	Hours Min. 8.1	Date of Birth Month, Day, Year) PRI 20,1954	9. Birthplece (State or Foreign County)				
	10a. State 10b. County	/ 10c. City, T	own or Location	7.57.51		10d. Inside City Limits				
ctor ctor	Md, N	IA PA	LIMORE			1 des 2 □ No				
Dire	10a. Street end Number	CUTH GT	10f. Zip Code	220	10g. Cifizen of W	/het Country?				
ne 23	11. Marital Status	12. Was Decadent Ever in U.S.	13. Was Decedent of H	lapanic Origin? (Specify	Yes or No- 14. Race	- American Indian,				
D	1@Never Married 2□ Married 3□ Wildowed 4□ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yea, Give Year or Dates:	If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	p, Mexican, Puerto Rica Specify:		BIACK				
natural dical	15. Decedent's E (Specify only highest gr	ducation t ade completed)	(Give kind of work done of	furing most of working	16b. Kind of Bu	sness/Industry				
the Man	Elementary/Secondary (0-12)	College (1-4or 5+)	LATURE	R	Ci	TV				
Se office	17. Father's Name (First, Middle, Las	0 0 -11	FF1.100.1 No.	18. Mother's Name (F)	st, Middle, Maiden Surnam	/				
Menta arked effic er	GEORGE T	SMITH		KOGALII	E ROUZE	R				
band and	19a. Informant's Name/Relationship	gros. Pino. TH	19b. Mailing Address (Street	and Number or Rural Ro	use Number, City or Town.	State, Zip Code)				
Heath ann 2 Other	20a. Method of Disposition	20b. Place		2011/1	ate 20c Location	City or Town, State				
The state of			otory, cromatory or other place	19/4	4/00 Longer	unk Md				
y inju			22 Namedana Andrea	MARCA	EUNERO/AD	ME PA				
10118	Mona [] []	ford	270 PR	DHILTON	MASS BAH	md.21279				
	23a Part Ehun the stream, or con shook, or heart failure. List only	polications that caused the death. It one cause on each line.	Do not enter the mode of dyin	g, such as cardiac or re	spiratory arrest,	Approximete finterval Between Onset and Death				
hysician /Medical	Immediate@ause (Final									
xaminer	disease or condition resulting in deeth)		s a consequence of):							
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and Il-tran	Sequentially list conditions, if eny, leading to immediate	Due to (or es	s e consequence of):		HINGE ST					
	cause. Enter Underlying Cause (Disease or Injury that Initiated events									
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atten of for us	Part II. Other significant conditions	and the single so don't be to go and the	and the supplementation assume also	en in Dead	22h Did tohenno use nor	atribute to the cause of deeth?				
by the tache	Pett II. Other significant conditions	commoding to death but not resulti	ig in the underlying cause giv	en in Pen I.	1 Yss 2 No 3 Probably 4 Unknow					
be de pe de										
should should					24a. Was an autopsy performed?	24b. Were eutopsy findings eveilable prior to completion of cause				
a has liga 2 s					1 <del></del>	of deeth?				
tor, pe	25. Was case referred to medical			26. Piece of Death (C		100 163 20110				
direc	examiner? 1  Yes 2  No	Hospitel: 1 Inpatient 2 TER	Mospital: Other							
	27. Menner of Death 1 ⊠ Neturaf 5 □ Pending	(Month, Day Year)			28d. Describe how injury occurred					
death stor: / tha f	3 Suicide 6 □ Could not I	be See Place of Injury At home			281. Location (Street and Number or Rural Route Number,					
d in b	4 Homicide determined	building, etc. (Specify)	s, raini, alloct, ractory, onice		City or Town, State)					
		hysician: To the best of my knowle	dge, deeth occurred at the tin	ne, date and place, and	due to the ceuse(s) end me it the time, date and place,	nner as stated.				
n 24 hour Pleisty fills	29e. Certifier (Check only one)  1 Certifying P	and menner steted.	and or my oonganon, army o	piriloni, deetri occarieo e		and due to the cause(s)				
Tothe Funan completely fill	(Check only 2 Medical Exa	miner: On the basis of examinetion and menner stelled.	29c. Licens	e number	29d. Dete signed	and due to the cause(s)  d (Month, Day, Year)				
Tothe Funan Tothe Funan completely fill	(Check only 2 Medical Example of Continuous	Chule in	29c. Licens		29d. Dete signed	and due to the cause(s)				
offinin 24 hour Tothe Funera complinely fills	29b. Signeture end title of certifier  29b. Neme and eddress of person who	Cluste in completed cause of deeth (Item 23	29c. Licens O。C	e number .M.E.	29d. Dete signed October	d (Month, Day, Year)				
Tothe Funers Tothe Funers complesely file	(Check only 2 Medical Example of Continuous	Chule in	29c. Licens O.C 3e) (Type, Print) 111 Penn S	e number .M.E.	29d. Dete signed	d (Month, Day, Year)				
	rs after death.  Is aft	Physician //Medical Examiner  1. Decedent's Name (First, Middle, Last)  4. Facility Name (II not institution, girling)  4. Facility Name (II not institution, girling)  5. Social Security Number  6. Director  10a. State 10b. County  10b. County  10c. State 10b. County 10c. State 10b. County 10c. State 10b. County 10c. State 10b. County 10c. State 10b. County 10c. State 10b. County 10c. State 10b. County 10c. State 10b. County 10c. State 10b. County 10c. State 10c. State 10b. County 10c. State 10c. State 10b. County 10c. State 10c. State 10c. County 10c. State 10c. County 10c. State 10c. State 10c. County 10c. State 10c. County 10c. State 10c. County 10c. State 10c. County 10c. State 10c. Stat	Physician Medical Examiner  1. Decedent's Neme (First, Middle, Last)  1. Decedent's Education (Speedy) only highest grade completed)  1. Decedent's Education (Speedy) (Speedy) only highest grade completed)  1. Decedent's Education (Speedy) only highest grade completed)  1. Decedent's Education (Speedy) (Speedy) only highest grade completed)  1. Decedent's Education (Speedy) (	Physician   Indecical Examiner   Indecided   Indecided	Physician // Decoder's Neme (Frat, Middle, Last)  Physician // Reditable Neme (Frat, Middle, Las	Physician Medical Physician Application of December 1 and Fight 2 and 1				

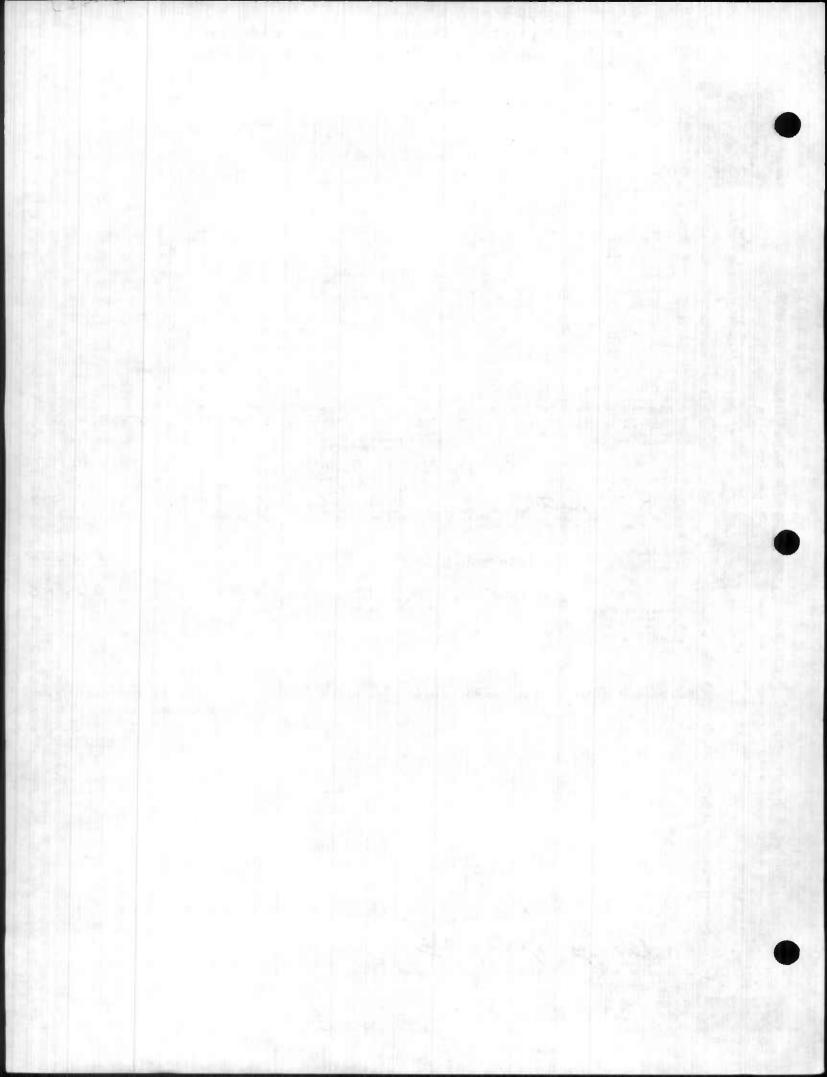


00-5780-510		State of Maryland			ental Hygi	ene [] []	32533			
ANNIE SCOTT			Certificate of	Death		g. No.	2 Time of Death			
Physician	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Dey Yaer	3. Tima of Death					
/Medical	ANNIE	CRE DELIA	SCOTI	4b. City, Town, or Lo	OCTOBER		11:08 A			
Examiner	4a Facility Name (If not institution, give str				Jation of Death	4c. County of Deer	6			
	1102 DRUID HILL 5. Sociel Security Number 6. Sex	AVE 7. Age (In yrs. las	st hirthday) If Under 1 Year	BALTIMORE  If Undar 24 Hrs.	8. Data of Birth	N/A	tholeca (State or Foreign			
Funeral Director	214-20-729\$ 10M	1 2×F 75	Yrs. Months Deys		(Month, Day,	1925 500	thplece (Stete or Foreign buntry)			
	Usual Residence of Decedent	/)			SEPIZI	1/20 000	AT II CHROCING			
yland	10a. Stete 10b. County	10c. City,	Town or Location				10d. Inside City Limits			
Mer Mer Tor	MARYLAND N/A		BAL	TIMORE	CIT	1	1XX Yes 2 □ No			
or 28a-f a	10e. Street and Number		10f. Zip Code			g. Citizen of What Co	ountry?			
ter death with the Meryland thems 23s or 28s-1 show the most be notified at all thems all Director	1602 DRUIL	HILL AVE	ENUE	2121	7	USA	_			
	11. Marital Stetus	. Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Spe	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit				
s after s, or he same, y Fu	1 Nevar Marriad 2 Married	1 Yes 250No	1 □ Yas 2 X No			Specify: /	1 - 0 /			
0 5 44 4	3/S_Widowed 4 □ Divorced	Year or Detes:				100	LACK			
	15. Decedant's Educe (Specify only highest grada of	tion completed)	16e. Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	ipetion a during most of worki	ng 1	6b. Kind of Business	/Industry			
	Elementery/Secondery (0-12)	College (1-4or 5+)				500 016	-040.71			
a fied will Hygien other th	17. Fether's Name (First, Middle, Last)	VRS	ENUNERAT	18. Mother's Name	(First Middle M	SOCIAL S	BOURTY			
Maryland 212 and 2 should be filed within anth and Marylane. 77 la marked other than traumatic avant, the structure of the st			TAUGE	MARI			1.1.5			
Marylan 42 should be h end Mental h end Mental r la marked o braumatic av	SAMUEL  19e. Informent's Neme/Reletionship (Type	Print	JONES  19b. Mailing Address (Street				Zip Coda)			
Ma d 2 s d 2 s th en T la trau	MARIENE BOWIE	= (SISTER)	15 CHARLES	_	-		MD. 2120/			
Has Has Shar	20a. Method of Disposition	20b. Ple	ce of Disposition (Neme of			Oc. Location - City or				
DI BERRY	Burlal 2 Cremetion 3 Ren	noval from Stata cen	netery, cremetory or other pl		111 00 1					
Iting the standard st	4 Donation 5 Other (Specify) 21 Speature of Funeral Service (licknsae	MI	22 Name and Add	netery 10	-14-00 L	ANS DOLL	INE MARYLAND			
B Ba			JOSEPH	ress of Facility H. BRO	ON JR.	FUNERAL	HOME			
1 2 2 2 2 2 2	My physical	2140 N. FULTON AVE, BALTIMORE, MO. 212								
	23a. Par 1. Enter the diseese, or complica shock, or heert failura. List only one	cause on each line.	Do not enter the mode of dy	ring, such as cardiec c	r respiretory erre	St,	Approximate Intervel Between Onset and Deeth			
Physician /Medical	Immediate Ceuse (Final	1	A /	1 1.	2.					
Examiner	diseese or condition resulting in deeth)	Hyperrensive		Ardiovascul	in Disease	9				
5		Due to (or e	es e consequence of):							
), axecuted n and iel-transit Examiner	b	2 /								
60, be axecutician and burial-trar	Sequantielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury c.									
Box 68760, eath certificate be associted attending physician and for use as the burial-transit claryMedical Examir	Ceuse (Disease or Injury that initieted events	Due to /or e	as a consequence of).							
	resulting in death) Lest	Due to (or es e consequence of):								
P.O. Box 68 tat the death certifice d by the enending ph etached for use as tr	d									
. 77	Pert II. Other significant conditions contri	buting to death but not result	ing in the underlying cause of	iven in Pert I	23b. Did tol	bacco usa contribut	a to the cause of death?			
	Total digital dollars continue	ang ar and directlying occord	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		. Did tobacco uss contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknow					
					, , ,		, ,			
Records, P na law requires that s has been signed b oge 2 should be deter					24a. Was ar		Were eutopsy findings available prior to			
0 - 0 -					perform	1907	complation of ceuse of deeth?			
The law require the has been sipped 2 should Completed	The late of the la				108 Ye	s 2 No	1 No 2□ No			
f Vital Receipted to Securificate has director, page 2 To Be Comp	25. Wes case referred to medical			26. Place of Deeti			1,5 100 22110			
Of Vita Physician: this certific rai director,	eveminer?	spitel: 1   Inpatient 2   E	R/Outpatient 3□ DOA O	Mhor		nce 6 X Other (Spe	ecity) SCENE			
Division of Vital site death. Director: After this certificat d in by the funeral director, p ertification: To Be C.	27. Menner of Death		28b. Time of 28c. Inj			w injury occurred	W DOLLAR			
ion ath. After a fun	1 Neturel 5 Pending 2 Accident Investigation	(MORITI, Day Year)		Yes 2□No						
Arte production of the party of	3 ☐ Suicide 6 ☐ Could not be determined	28e. Piece of Injury - At hom	ne, ferm, street, fectory, office		28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)					
Division of the or Attanding P is after death.  al Director: After ied in by the funer certification:	4   Nomicide	building, etc. (Specify)		- 2.30	City of Town	, Siele/				
Division o within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying Physic	ian: To the best of my knowl	edge, deeth occurred et tha	time, date end plece,	end due to the ce	use(s) and menner e	s stated.			
ne Hospi n 24 hou ne Funer pletely fiii edical	(Check only 2 Medical Examine one)	r: On the basis of examinetic end menner steted.	on end/or investigation, in my	opinion, death occurr	ed at the time, da	ite end piece, end du	e to me cause(s)			
Division of To the Hospital or Attanding Phys within 24 hours after death. To the Funeral Director: After this opmpletely filled in by the funeral di	29b. Signetura and title of Cartifier	111		nsa number	29	d. Date signed (Mon				
	1 UM	1.1/	.M.E		1,2000					
. MO	30. Neme end address of person who com	pleted ceuse of death (Item 2	23e) (Type, Print)	4 100		0.00				
	JACK MI TI	ns, M.D.	111 Pen	n Street,	Baltimor	re, Maryla	nd 21201			
State	31. Data filed (Month, Day, Year)	32. Registrer's Signetu								
Registrar	OCT 1 6 200	Senera	B Space	Ks		74-5				
		w /	4 4							

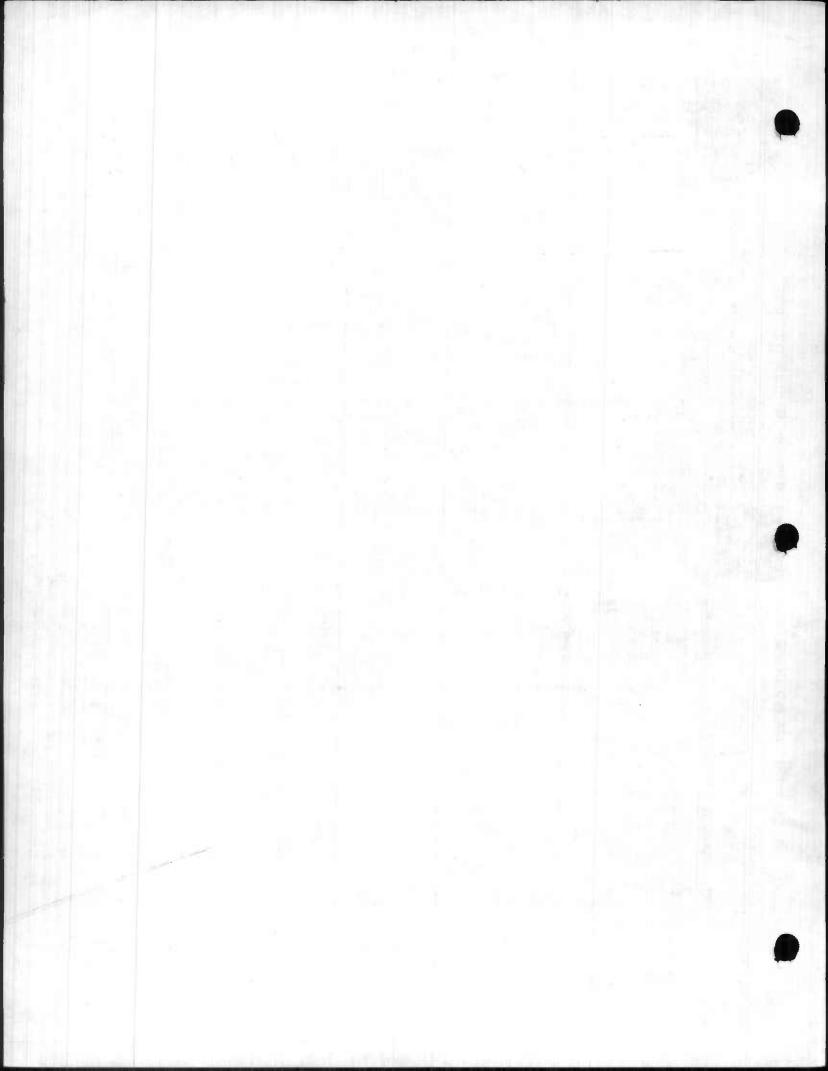


State of Maryland / Department of Health and Mental Hygiene

			Certifica	ate of	Death	F	leg. No.	3 3	2334
Physician	1. Decedent's Neme (First, Middle, Last					2. Dete of Dee	th Day	Year	3. Time of Death
/Medical		BAUER SIS	SON			October	10,20		4:30 pm
Examiner	4a Facility Nama (If not institution, giva		0 -		46. City, Town, or L Rosedale	ocation of Death	BOLLI	more	
	Franklin Square Ho			nder 1 Year		8 Data of Birtl			
Funeral Director	214-34-3792 XX	M 2□F 68	Yrs. Month		Hours Min.	8. Data of Birtl (Month, Day 02-16-	1932	Countr	aca (Stata or Foraign ry) LAND
ž==	Usual Rasidence of Decedent  10a. Sleta 10b. County	10c. C	ity, Town or Location				100	10	d. Inside City Limits
ural; or items 23a or 28a-f show at Examiner must be notified at cd by Funeral Director	MD. BALTIN	MORE	BOWLE	YS	QUARTERS	5			1 ☐ Yes XXNo
be notified Director	10a. Street and Number 820 COLDSPRIM	IG ROAD	10f.	Zip Code	220		U.S		ry?
		12. Was Decedani Evar in U	16 12 Wee De		Hispanic Origin? (Sp	posity Voe or No.		e - Amarica	n Indian
ar, or items 234 Esaminer must by Funeral	11. Maritel Status  1 Never Merried XX Merried  3 Widowed 4 Divorced	Armed Forcas?  KNas 2 N 95 If Yas, Giva Yeer or Dales: 195	2- If Yas, s	specify Cub	Specify:	o Rican, atc.)		ck, Whita, a	
	15. Decedant's Edu	cation	16a. Decedent's U	Jsual Occu	pation	king	16b. Kind of 8	usinass/Indu	ustry
ner than "natural, the Medell	(Specify only highest gred	Collega (1-4or 5+)  YEARS			during most of world)  OPERATO		FLOR	IST	
d other event, I Be Cc	17. Father's Nama (First, Middla, Last)	LEARS			18. Mothar's Nam	na (First, Middle,	Maiden Suman	na)	
	EDWARD B. SI	SSON			MARGAI	RET C.	BAU	ER	
0 2	19a. Informant's Name/Ralationship (7) ERNESTINE I.SIS				rend Number or Ru ING RD.				Coda) 5,MD.212
20	20a. Mathod of Disposition		Place of Disposition (cematery, crematory	(Nama of or other pla	ice)	Date	20c. Location	- City or Tow	vn, Slele
ury of	4 Donation 5 Othar (Specify)		GARDENS	OF F	AITH	10-14	BALTI	MORE,	MD.2120
Important: any injury once.	21. Signatura of Funaral Sarvice Licens	22 22	HENR	Y W.	JENKINS  K ROAD,	S AND S	ONS CORE, MAI	OMPAN RYLAN	IY VD,21212
	23a. Part1. Entar the disaesa, or compleshock, or heart failure. List only o	licetions lhat caused tha daa na causa on each lina.	ith. Do not anlar tha n	mode of dy	ing, such as cardiac	or respiratory en	rast,		Approximata Intarval Batween
rsician ledical aminer	Immediata Causa (Final disaasa or condition	PULMONARY	EDEMA						Onsat and Death
10	rasulting In death)	Dua to	(or as a consequence				W.		WEEKS
in and riel-transit Examiner		CONGESTION			ATION, S	EVERE			WEEKS
ician and buriel-trai	if any, leading to immediata causa. Entar Undarlying	Dua to t	or as a consequence	OI).				1	
physician and as the buriel-transit edical Examir	Sequantially list conditions, if any, laading to immediate causa. Entar Underlying Cause (Disease or injury that initiated avants rasulting in death) Lest Due to (or as a consequence of):								
g 2 2		d							
Ifor usa Clan/N									
ed by the attending deteched for usa to Physician/M	Part II. Other significant conditions con	23b. Did tobacco use contributs to the cause of death?  1 Yes 2 No 3 Probably 4 Unknow.							
be dett							2/20110	0   1   10	201)
pege 2 should be Completed t							an autopsy med?	eve	ra autopsy tindings iilabla prior to appletion of causa
has b					No.				npletion of causa leath?
	25. Was casa ratarrad to medical	Market St.		11/10/	00 Disease of Des		as 2 No	1	Yas 28 No
al director	axaminar?	Hospital: 1 Minpatiant 2	☐ ER/Outpatient 3☐	DOA O	26. Placa of Das	loma 5 ☐ Rasio		har (Specify	1)
		28a. Data of Injury (Month, Day Year)	28b. Time ot Injury	28c. Inju		28d. Dascribe I			
or: Aff	2 Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	M		Yes 2□No				
al Director: After tiled in by the funere Certification:	3 Suicida 6 Could not be detarmined 28e. Place of Injury - At home, tarm, streat, tactory, office building, atc. (Specify) 28t. Location (Streat end Number or Richtstein, Streat) 28t. Location (Streat end Number or Richtstein, Streat end Number or Rich								I Route Number,
within 24 hours a to the Funeral Dag pletsly filled i		elclan: To the best of my kn ner: On the basis of axamin and mannar stated.	owledge, death occur ation end/or investigat	red at tha t ition, in my	ima, data and place opinion, daath occu	, and dua to the rred at tha tima,	causa(s) and m data and place,	anner as sta , and due to	ated. tha cause(s)
So the state of th	29b. Signatura end titla of certifiar	Martin	140	_	se number		29d. Data signe		Day, Year)
2	Lavanya gallagada RD203406						10-10-	.00	
70	30. Nama and address of person who co						L. U.L.		
0	DR Lavanya Yark		-ranklin Sal	vare i	drive Bal	timore	mudia	377	
State	31. Dala tiled (Month, Day, Year)	32. Ragistrer's Sign	natura /4	1					

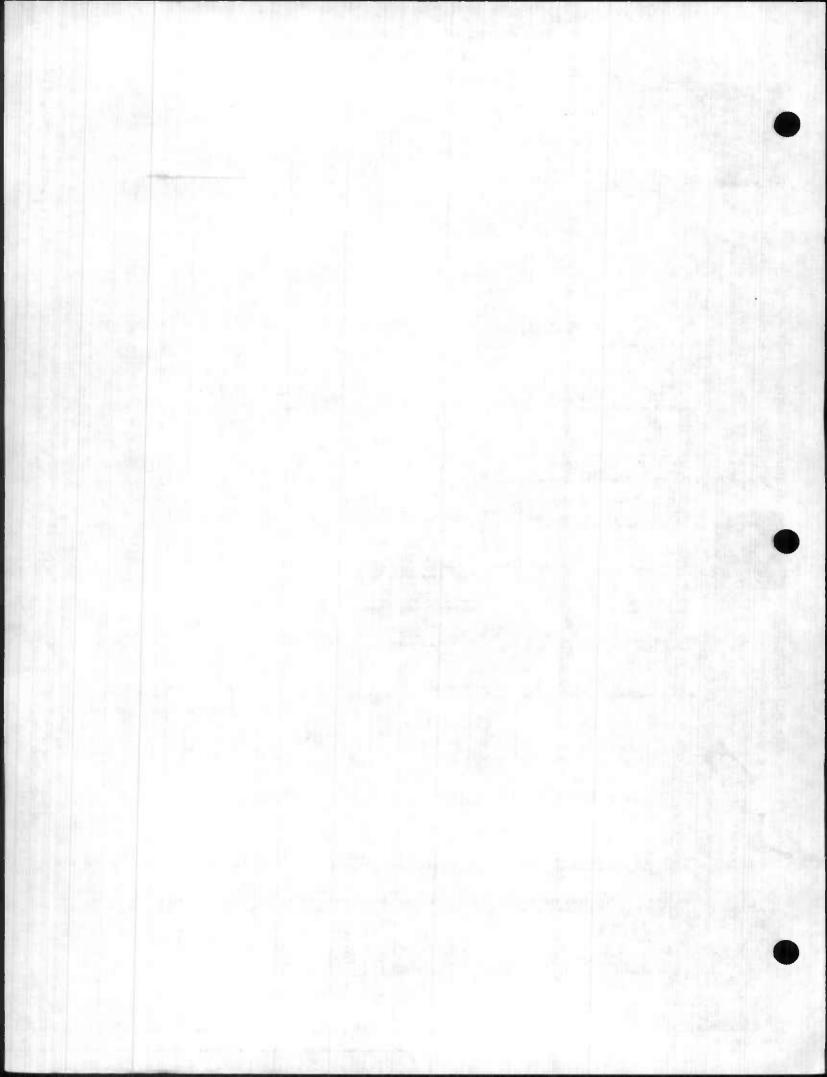


AMI	END#4A&10E PE		10-31-200			tificate of	Death		Reg. No.	0	32535
Physician /Medica	NANC	Ab City Town or	OCT. 09 2000 10:45			3. Time of Death $10:45\text{PM}$					
Examiner	8415	(If not institution, give SELLONA I		er)			TOWSO		Death 4c. County of Death BALTIMORE		
Funeral Director	216-46-	5. Social Security Number 6. Sex 1 M 2			7. Age (In yrs. last birthday) If Under 1 Year Months Days			24 Hrs. 8. Date of Birth Min. NOV • 151913 MD • 9. Birthple Country MD • 151913 MD • 15191		laca (Stata or Foraign try)	
land and	Usual Rasidenca d	10b. County	10c. City, Town or Location						10	0d. Inside City Limits	
Mary Mary	MD BALTIMORE TOWSON										1 ☐ Yas 2 No
In with the Marylar 23a or 28a-f show at be notified at		ELLONA L	ANE	10f. Zip Code VE 21204				10g. Citizen of W	hat Coun	try?	
020 ors after death v er, or frame 234 Examiner must	3 ₩ Widowed	1 Yes 2	☐ Yes 257No			Decedent of Hispanic Origin? (Specify Yes or Ns, specify Cuban, Mexican, Puerto Rican, atc.) Yes 2点 No Specify:			14. Race - American Indian, Black, White, etc.  Specify: WHITE		
Maryland 21215-0020 of 2 should be filed within 72 hours at the and Mertal Hygiene. T is merived other than "natural", or traumalic event, the Medical Exam.	(Spe Elementary/Sec 1 2	15. Decedent's Edicify only highest grad		lifa. DO NOT use retired)							
be filed the tree that the tree that the tree that the tree that the tree tree tree tree tree tree tree		(First, Middla, Last)					18. Mother's Na	ma (First, Middle	, Maiden Sumeme	9)	
Via Ment	WALTER	F. WICK		CATHER				RINE YOUNG			
Mar nd 2 sh aith and 27 is m r traum		lame/Relationship (7) SHAW II				240	R RD. G				
Baltimore, semi. Pages 1 an appendent of Heat mportant: if them 2 may injury or other	20a. Mathod of Dis		Removel from Sta	20b. I	Place of Dispos cematery, crem	sition (Name of setory or other pla		Date	20c. Location - 0	City or To	wn, Stata
Baltil permit. P Departm Importer eny Injus and		unaral Sarvice Licens			22 H E	Name and Addre NRY W.		S & S01	IS CO.		, , , , ,
	23a. Part1. Enter shock, or her	the diseasa, or compart failura. List only of	lications thet cau	sed tha deal						12	Approximata Intervel Between
Physician /Medical Examiner	Immediata Cause diseasa or conditi resulting in death)	(Finet	· Acu		MYSC	14iasa	- inf	FARCTI	110		Onset and Deeth
P = 2			CON	Due to (0	or as a conseq			BiLun		1	WEEKS
58760, icete be executed physicien and s the burishtransit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.										
	resulting in death)	Last	d	Dua to (d	or as a consequ	ience of):					
	Part II. Other signi	ficant conditions co	ntributing to deat	h but not ras	ulting in the un	derlying cause of	ven in Part I	23h. Did	tohacco use con	tribute to	The cause of death?
is, P.O. Box es that the deeth certigined by the attending be deteched for use a by Dhusician M.									1 Yes 2016 3 Probably 4 Unknown		
aw requir									en eutopsy ormed?	cor	ore eutopsy findings eilabla prior to mptation of causa death?
= F 44 0								10	Yas 2 DUNG	1	Yas 2□ No
Of Vital Physician: The this certificate ral director, pag. To Be Co.		/	26. Place of Deeth (Check only/one) Hospitel: Other: Other								
0 5 5 7		th	1 ☐ Inpatient 2 ☐ 28a. Dete of tnjury (Month, Day Year)		LI EN Outpatient 3LI DOA		4 LI Nursing Homa 5 12 He		be how injury occurred		')
Vision Attending or deeth. ector: Afte by the fune	1 Netural 2 Accident	5 Pending invastigation	(WORIT,	Day Year)	Injury		Yes 2 No				
Division of To the Hospital or Attending P within 24 hours after deeth. To the Funeral Director: After to completely filled in by the funeral Medical Certification:									l Routa Number,		
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	29a. Certifier (Check only one)	1 ☐ Certifying Phy 2 ☐ Medical Exami	sician: To the be ner: On the basi and manner	s of examina	owledge, death ation and/or inv	occurred at the ti estigation, in my	me, date and place opinion, death occ	e, and due to the urred et the time,	causa(s) and mer date end placa, a	nner as st nd dua to	ated. tha causa(s)
Nithin Somple	29b. Signatura and	titla of certifier	) /	stateu.		29c. Licens	se number		29d. Date signed	(Month, i	Day, Year)
2	► M	Maria le Memon my 2000769						7	0ct 11	12	000
512	MARCIC	mass of person who comes M • MENE		of death (Item			E RD. T	OWSON.	MD. 212	04.	
State Registrar	31. Data fited (Mon	31. Deta filed (Month, Day, Year) 32. Registrar's Signature									



	Amended il	State of Maryland / Department of Health and M EM3 8 perFHG788 10/17/2000 EW Certificate of Death	Mental Hygiene 00 32536								
	Dhusisian	1. Decedent's Nama (First, Middle, Last)	2. Deta of Deeth Month Day Yaar 3. Tima of Death								
ς	Physician /Medical	Jean Parker Stricker	October 14, 2000 4:30 a.m.								
	Examiner	4a Facility Neme (If not institution, give street and number) 4b. City, Town, or L									
			tsville Harford Co.								
	Funeral	5. Social Security Number 20-14-3496 6. Sex 1 M 2 X F 7. Age (In yrs. last birthday) 8. Hours Min.	8. Dafa of Birth 9. Birthplace (Stata or Foraign Country)								
,	Director	220-14-3496 1 M 244 77 Yrs. William 25/3 West Residence of Decedent	FEB 7 1923 Maryland								
	Pand Mand	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits								
	Many Leh	Maryland Harford Co. Jarrettsville	1 ☐ Yes 2 No								
	vith the Ma to 28e-f • to notified Director	10e. Street and Number 10f. Zip Coda	10g. Citizan of What Country?								
	3a o	1425 Dalewood Drive 21084	United States								
	hours after death with the Maryland urel; or ferma 23e or 28e-f show at Esserteer must be notified a	11 Maritat Status 12. Was Decedent Evar in U.S. 13. Was Decedent of Hispanic Origin? (St									
0	P. Fu	Armed Forces?  1 Never Married 2 Merried I Yes 370No II Yes 2 X No Specify:									
00	ref., o	3 XWidowed 4 Divorced Year or Dates:	Specify: White								
21215-0020	72 54 46	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work	16b. Kind of Business/Industry								
12	within ene.	Elamentery/Secondary (0-12) College (1-4or 5+)	Hospital								
		12 Accounting  17. Father's Neme (First, Middle, Last)  18. Mothar's Nam	ne (First, Middla, Maiden Sumame)								
and	O SEES	Milton Katzenberger Etta	Parker								
Maryland	nd Men marke umatic		ral Route Number, City or Town, State, Zip Code)								
Z	th an trau	Mr. Joseph M. Stricker /Son 1425 Dalewood Drive	Jarrettsville, MD 21084								
ē,	f Heel f Heel frem 2 other	20e Method of Disposition 20b. Place of Disposition (Nama of	Dete 20c. Location - City or Town, State								
OH.	80=8	1 M Burial 2 □ Cremetion 3 □ Removel from Stete 4 □ Donetion 5 □ Other (Specify)  St. Mary S Govans Cem.	0/17/00 Baltimore, Maryland								
Baltimore	permit. Pe Departmen Important: any Injury once.										
B	pemit. Departm Importa any inju	ritulaet E. Callapp	5305 Harford Road								
		23a. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac shock, or heart failure. List only one cause on each line.	INC. Baltimore, MD 21214 or respiretory errest. Approximate								
	Physician	shock, or heart failure. List only one cause on each line.	finterval Batween Onset and Death								
4	/Medical	Immediate Cause (Finel disease or condition  MH05794127020011	and nova sand is								
	Examiner	disease or condition resulting in deeth)  Due to (or es e consequence of):	- Cardinary 1 mile								
	e e	Due to (at 65 6 contesquente of).									
	that the deeth certificate be executed ed by the attending physician and detached for use as the burial-transit / Physician/Medical Examiner	Sequentially list conditions.  Dua to (or as a consequence of):									
ó	an ar	if eny, leading to immediate cause. Enter Underlying									
-	hysicia he bu	Cause (Disease or injury C.  thet initiated events resulting in death) Last Due fo (or as e consequence of):									
c 68	oertifica Iding ph Ise as th										
Вох	nat the deeth certifical by the attending philaded for use as the Physician/Med	0.									
	the deep y the a ached for hysic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacco use contribute to the cause of death?								
	ed by detac		1 Yee 2 No 3 Probably 4 Unknown								
S	2 58 6		24a, Was en autopsy 24b. Wara autopsy findings								
0	requiponi		performed? evailable prior to completion of causa								
360	9 20 0		of deeth?								
ē	cate h		1 Yes 2 No 1 Yes 2 No								
Vitai Record	Physician: The lew this cartificate has that director, page 2 stall director, page 2 stall director.	examiner?	ce of Deeth (Check dnly one)								
ō	2 00 0	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing H	ome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred								
	After funer tion	1 Netural 5 Pending (Month, Day Year) Injury Work?	200. WOSSIDE HOW INJURY COUNTY								
S	or Attending after death. Director: After in by the fune ertification	3 Suicide 6 Could not be	28f. Location (Street and Number or Rural Route Number,								
5	tal or Attending P rs after death. al Director: After t led in by the funera Certification:	4 Homicide determined determined building, etc. (Specify)	City or Town, Stete)								
	Tours Funeral fely filled Ilcai C	29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece	end due to the ceuse(s) and menner as stated.								
		29e. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) and menner as stated.  (Check only one)  (Check only one)  (Check only one)  (Check only one)									
	New York	29b. Signifure and title of certifler 29d. Date signed (Mghth, Day, Year)									
	V	D36814 10/14/00									
-	UVI	30/Name and address of person who completed cause of death (ffer) 23a) (Type, Print)									
	A /	BOOMER 1 - Alustia MISTEDS OSTINDA SUITE 302 TOWARD MD									
	10	TXUMINO 6,4/US/16/11/0/1605 US/11/UR. SU	THE DOS TOWSTITIO								
	State	31. Dete filed (Month, Day, Year)  32. Registrer's Signetura	THE SON TOWSPITTING								
	State Registrar	31. Dete filed (Month, Day, Year)  OCT 1 6 2000  32. Registrer's Signetura	THE SON TOWSTITTIN								

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State of Maryland / Department of Health and Mental Hygiene

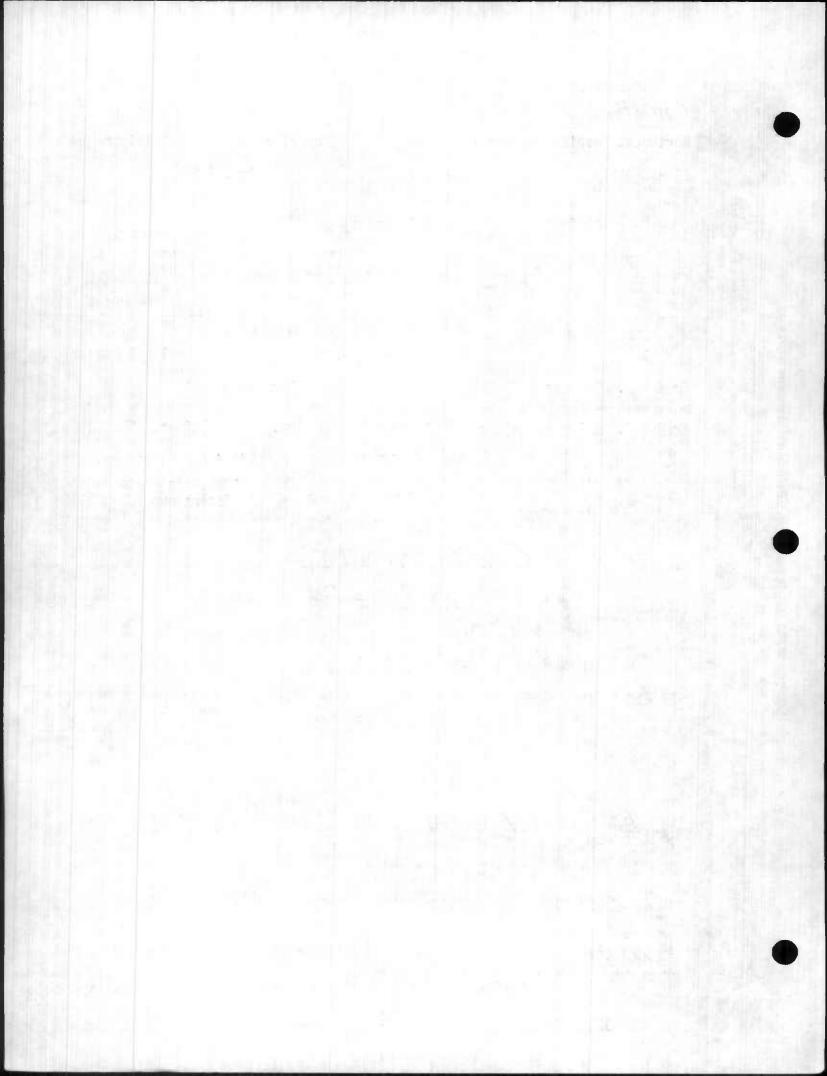
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					Ce	rtificate	e of	Death			Reg. No.		0 = 0 0 1	
Physicia		ama (First, Middla, L	ast)	ith						2. Data of De Month OC 10 64	Day	Yaar 2000	3. Tima of Death	
/Medica	4a Facility Name	(If not institution, g	ive street and nu	(mhar)				4b City To	own or t	ocation of Deal	-	nty of Death		
Examine		st Hospit						Randa				ltimor	^e	
Funeral	5. Social Security		Sex	7. Aga (in yrs. la	st birthday)	If Undar Months	1 Yaar	If Undar					placa (Stata or Foraign	
Director	215-58-	0257	1□M 2CXF	49	Yrs.	Months	Days	Hours	IVIII.	8. Data of Bi	1951	Cour	MD	
P >	Usuat Residence	of Decedent	7/13	400 City	Town or Lo	antion							IOd. Insida City Limits	
eho e				Too. Ony,									1 ☐ Yas 2 ☐ No	
the N	MD 10e. Street and N	Baltim	ore		Reisi	ersto					10g. Citizan o	of What Cour		
death with the Meryland ms 23s or 28s-f show count be retified at	5	yanstone	Road			101. 210	211	36			USA		indy i	
re 23	11. Marital Status			pedent Evar in U,S	. 13.	Was Deced			igin? (Sp	pecify Yas or No Rican, atc.)		lace - Amaric	can Indian,	
D 20	1 □ Navar Ma	arried 2 Married	Armed F	orcas? 2 X No						Rican, atc.)		lack, Whita,	atc.	
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72 hours	Elamantary/Se 12	15. Decedant's I	Education	)	16a. Dece	dant's Usua	l Occup	pation during mos	st of worl	kina	16b. Kind of	Businass/In	dustry	
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Ba Depa Impo	6 -0 1:										21136			
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Physician	shock, or h	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
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Division of Vital Records, to Attending Physician: The law requires the after closent.  Director: After this certificate has been signed in by the funerel director, page 2 should be additional or a second or a	4 Homicid	a datarmine	build	ling, atc. (Specify)	ina, iaiiri, si	aai, iaoioiy	, omca			City or To	wn, Stata)			
9 5 E 9	29a. Certifier	12 Certifying F	hveician: To the	a best of my know	iedga, daat	n occurred a	at tha ti	ima, date a	nd place	and dua to the	causa(s) and	mannar as s	stated.	
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#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month Leanna Mary Stanton 4:50 PM ,2000 October 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Kosedal ranklin Square Center Baltimore Hospital (In yrs. last birthday) If Undar 1 Yaar If Under 24 Hrs. 8. Dete of Birth Month, Dey, Year, March 11, 9. Birthplece (State or Foreign Country) 7 Haryland 5. Social Security Number 10 M 20 F Deys Hours 215-03-4327 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No Md. Baltimore Perry Hall 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 104 Jumper Circle 21236 U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuben, Maxican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Nevar Merried 2 Merried 1□ Yes 2No Specify: Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Homemaker : Housewife 18. Mothar's Name (First, Middla, Maidan Sumama) 17. Fether's Neme (First, Middla, Last) Harry Keen Eula Milburn 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Leslie Stanton - Husband 104 Jumper Circle, Perry Hall, Md. 21236 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem. Park Oct. 14, 2000 Sykesville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition rasulting in daath) . Houte Cerebrovascular Accident Due to (or as a consequence of): Hypertension Sequentially list conditions, if any, leeding to immadiate ceuse. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Arteriosclerotic Cardiovascular Disease, Diabetes Mellitus 24b. Were autopsy findings svailable prior to completion of ceuse of death? 24e. Was an autopsy Artery Bypass Graft 1 Yes 2 No 2 No 1 Yes oronary 25. Was case referred to medicel examinar? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 28a. Date of Injury (Month, Dey Year) 27. Magner of Death 28c. Injury et Work? 28b. Tima of 28d. Describe how injury occurred 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a Certifier

100 Box P.O. Records, page of Vital Division or Attending After death. Director: after To the Hospital within 24 hours a To the Funeral C completely filled

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29b. Signature and title of certifier

30. Name and address of pars

31. Date filed (Month, Day, Year

Marco

32. Registrer's Signature

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completed cause of death (Item 23a) (Type, Print)

29c. Licanse number

. 9000 Franklin Square Drive Baltimore Maryland 21237

29d. Dete signed (Month, Day, Year)

October 11, 2000

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State of Maryland / Department of Health and Mental Hygiene 32539 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death IRENE AMELIA STEARNS October 10,2000 1:35 pm 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 20XF Months Davs Hours Min 91 Jan 14, 1909 Nova Scotia 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore County Anneslie 10f. Zip Code 10g. Citizen of What Country? 715 Dunkirk Road 21212 USA 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gates Genevieve 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. William Stearns (Husband) 20a. Method of Disposition 715 Dunkirk Road, Baltimore, Maryland 21212 e of Disposition (Name of Dete 20c. Location - City or Town, State Ptece of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 【XCremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 10/16/2000 Baltimore, Maryland Green Mount Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory effect,

Approximately 110 of the provided of the provid Approximata tnterval Between Onset and Death emplusemen years Due to (or as a consequence of). Due to (or es e consequence of): Due to (or as a consequence of) 23b. Did tobacco usa contributa to the causa of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were sutopsy findings 24a. Wes an autopsy evailable prior to completion of ceuse of daath? Reguszitation 25. Was cose referred to medicat axaminar? 1 Yes 20 No 1 ☐ Yes 2 ☐ No 26. Placa of Death (Check only ona) Hospitat: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 12 Certifying Physician: To the best of my knowledge, death occurred at the fima, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Box 68760 P.O. Records, of Vitai Division

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5. Social Security Number

215-24-5973 Usual Residence of Deced

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tmmediate Causa (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events

that initiated events resulting in death) Last

1 Yes 2 No

27. Manner of Death

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29a, Certifier

State Registrar

**DHMH 16 Rev 6/95** 

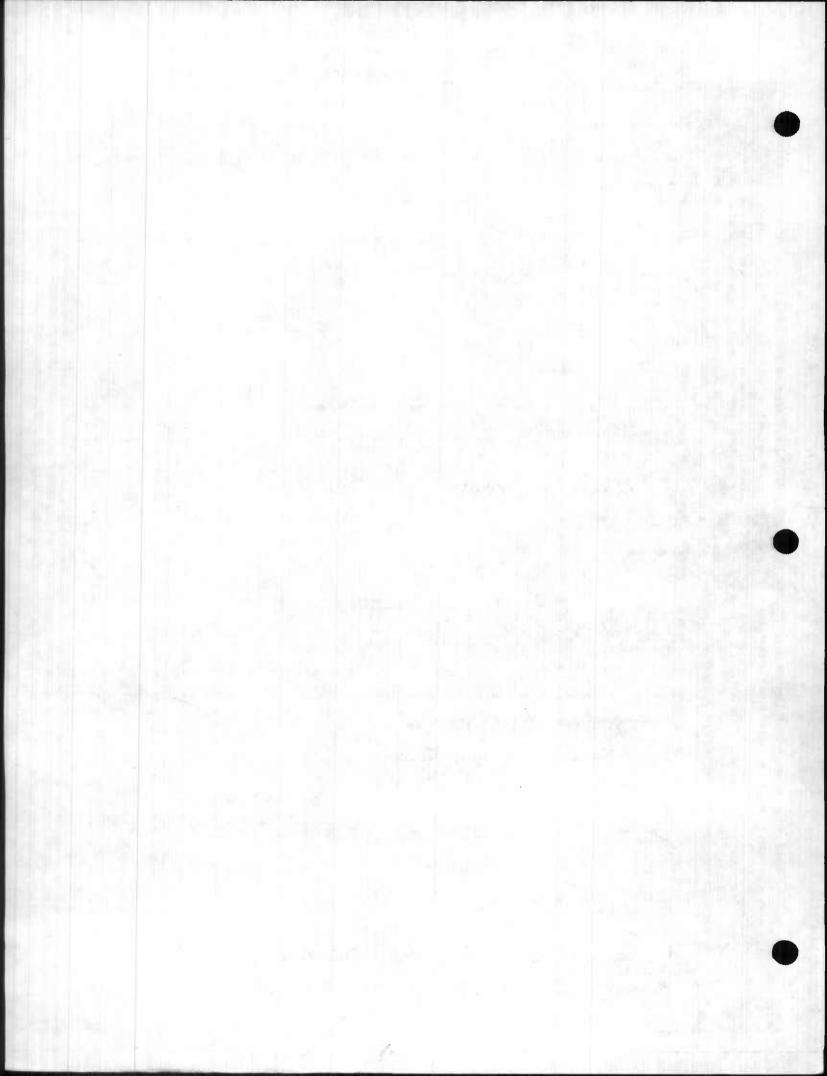
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ROSENBERG 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of parson who complated causa of daath (Item 23a) (Type, Print)

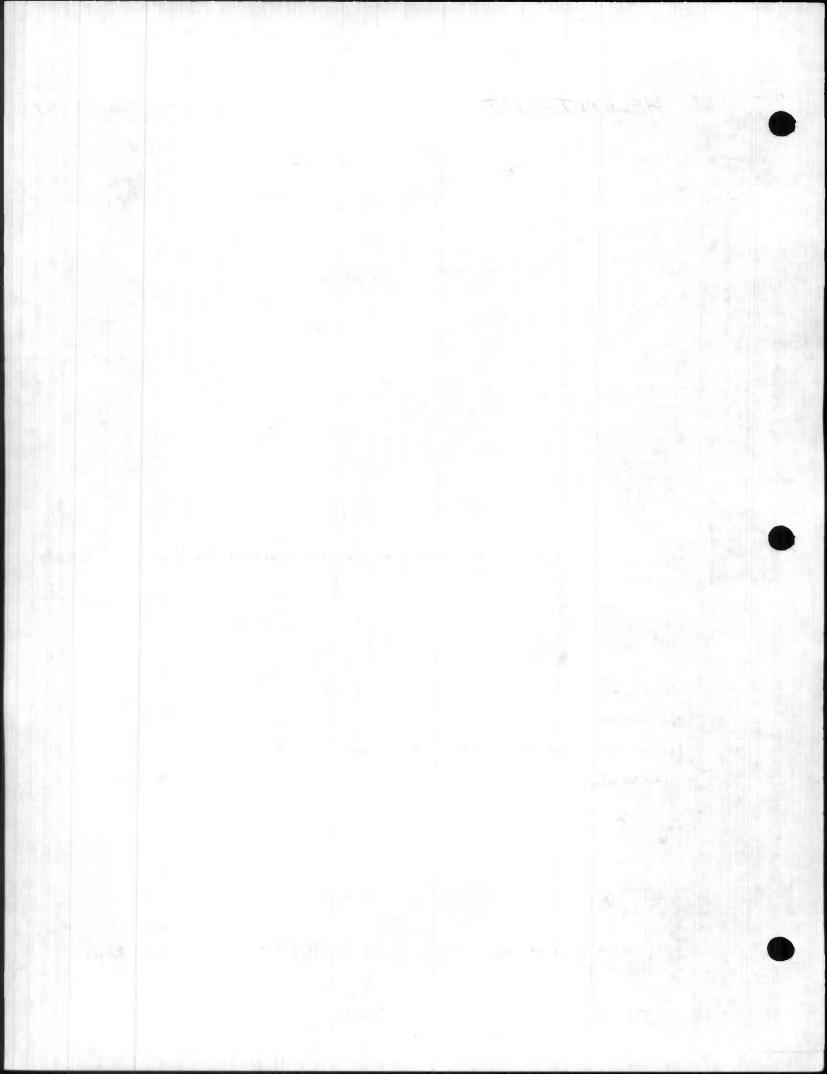
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	AMEND IT	M:	State of 31 PER D.V.R. G788 10–16–00 WR.		/ Department of F Certificate of			iene	32540
200	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last) HELEN TRUST				2. Date of Deat Month OCTOO	Day Yes	00 12:04 PM
	Examin Funeral Director	er	215076308 1DM 2	A	orer	4b. City, Town, or Lo  BALL  If Under 24 Hrs.  Hours Min.	mon C  8. Date of Birth  08/12/08	4c. County of Do	Seth  Market  Sinthplace (State or Foreign  Country)  ARYLAND
	pue *	6	Usual Residence of Decedent  10a. State 10b. County	10c. City, 1	Town or Location				10d. Inside City Limits
	Meryl she	to	MD BALTIMORE	ESS	SEX				1 ☐ Yes 2Ž No
	r 28s	Director	10e. Street and Number	100	10f. Zip Code		11	0g. Citizen of What	Country?
	death with the Meryland ms 23a or 28a-f show	alD	13A GLENWOOD ROAD		21221			USA	
020	or its	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedamed For 1 Yes, Gwe Year or Da	2 (XNo	13. Was Decedent of H If Yes, specify Cub  1 Yes 2 No	tispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, W	nerican Indian, hite, etc. VHITE
21215-0020	n 72 h	Be Completed	15. Decedent's Education (Specify only highest grade complated)  Elementary/Secondary (0-12)  Collega (1-		16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire CLERK	during most of worki	ing	OFFICE	
	filed Hygin other ent, t	Ö	17. Father's Name (First, Middle, Last)		OLLIUC	18. Mother's Name	(First, Middle, N		
Maryjand	d 2 should be filed within and Mental Hygiene. 7 Is marked other than traumatic event, the Mental traumatic event, the Mental traumatic event, the Mental traumatic event.	ToB	CHARLES HRDLICKA			MARIE K	OZLOVSKY	Z	
lan	2 should and Men is marks sumatic		19a. Informant's Name/Relationship (Type, Print)	147	19b. Mailing Address (Street	and Number or Rure	I Route Number	City or Town, State	e, Zip Code)
	Health Hem 27 other tr		MARIE E. SCHROETER/NIECE		6719 UNIVERS to of Disposition (Name of	SITY DR.		RE, MD 212 20c. Location - City	
aitimore,	Pege nent o nent: if		20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □ Removal from S  4 □ Donation 5 □ Other (Specify)	tate	netery, crematory or other pla Z REDEEMER	1	100	BALTIMORE	
Bai	permit. Pe Departmer Important: any injury		21. Signaturing Funeral Service Licensee	2)		ess of Facility SEDALE FUN ACO AVE BA			7
Ž.,			23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death. ch line.	Do not enter the mode of dyi	ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Batween Onset and Death
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P.0.	the a	ysic	Pert It. Other significant conditions contributing to dea	th but not resulting	ing in the underlying cause given	ven in Part I.			ute to the cause of death?
	that the by detection	Y Ph	denertia.				1 🗆 Y	es 2□No 3□	Probably 4 Unknown
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<u>ت</u>	The ate h	Con	Tures afor sice				1 U Y	s 2 No	1 ☐ Yes 2 ☐ No
Vita	sidector, pege 2 s	Be	25. Was case referred to medical examiner?		0	26. Place of Deat	h (Check only on	Θ)	
o	Physician: rthis certific ral director,	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ In 27. Menner of Death 28a. Date of		-Voutpatient 3LI UOA			once 6 Other (S	pecify)
ivision	To the Hospital or Attanding Physician: The inwitin 24 hours after death, within 24 hours after death, for the Funeral Director; After this certificate he tompletely filled in by the funeral director, page	Certification:	1 Netural 5 Pending (Month 2 Accident investigation	n, Day Year)	Injury Wo	Yes 2 □ No		reet and Number or	Rural Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled I	edicai	29a. Certifier (Check only one)  15 Certifying Physician: To the basend mennion	sis of examination	edge, death occurred at the tine and/or investigation, in my o	me, date and place, opinion, death occurr	and due to the cred et the time, d	ause(s) and manner ete end plece, and d	es stated. due to the cause(s)
	To the To the Company	X	29b. Signature and title of certifier		29c. Licens		2	9d. Date signed (Mi	onth, Day, Year)
	N		Millard Pursoner		DI	9667	- m 7	10-14-2	2000
	vy		30. Name and address of person who completed cause MICHAEL H. SCHWARTZ 5517 -A R		3a) (Type, Print)				
	Stat Registra	.6	31. Date filed (Month, Day, Year) 32. Re OCT 1 6 2000	gistrar's Signatur	3 Sparks				

DHMH 16 Rev 6/95

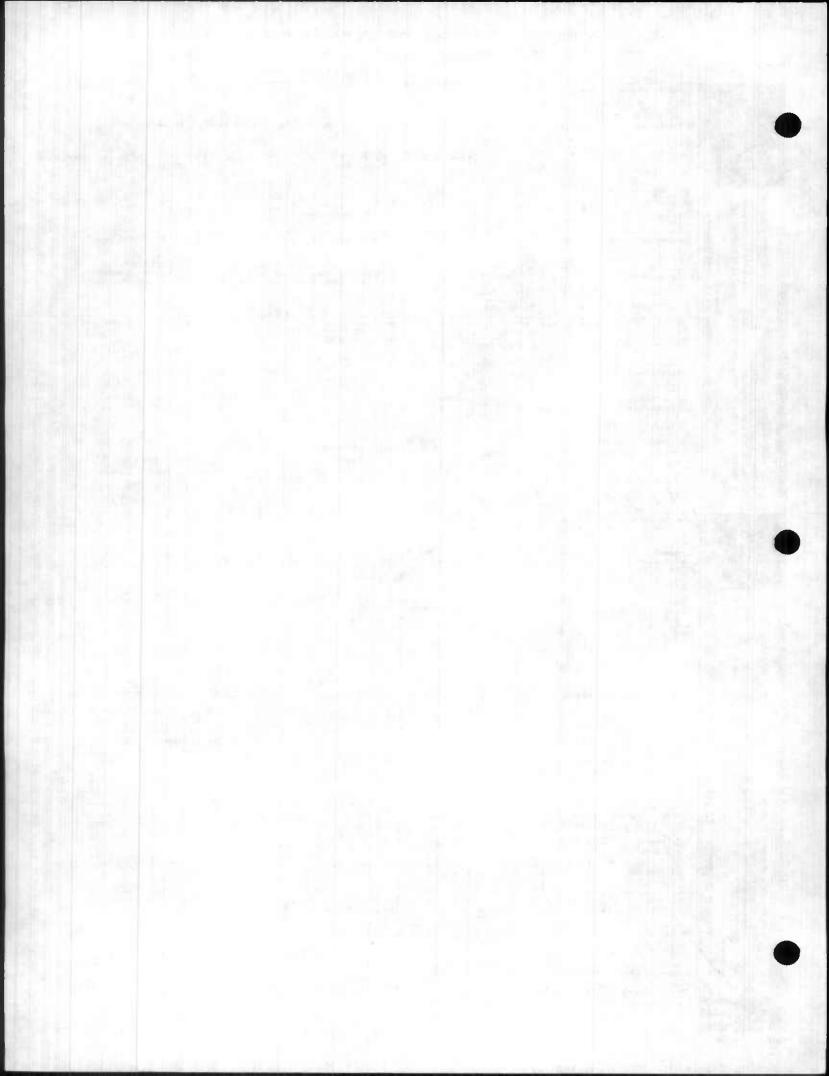


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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											Reg. No.						
Physician /Medical	1. Decedent's Name	YOUNG	}							2. Date of D Month OCTOB	ER 8,	Yeer 2000		of Death : 02am			
Examiner	4e Facility Name (If r			umber)			4			ocation of Dea	th 4c. Cour	nty of Deeth					
	1501 KI			7. Age (In v	rs. lest birthday)	If Unde	r 1 Year	BALT			irth	N/A	olece (Stet	e o <i>r Foreig</i> n			
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ž ==		10b. County		10c.	City, Town or Lo	ocation						1	IOd. Inside	City Limits			
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or 21	10e. Street and Numi	ber				10f. Zip	p Code				10g. Citizen o	of What Cour	ntry?				
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0		WESTON	1					ANI	VE F	ELIZAB	ETH ST	TASIL					
-	19e. Informent's Nen	ne/Reletionship (	Type, Print)		19b. Meili	ing Address	s (Street	end Numb	er or Rui	al Route Num	ber, City or Tov	vn, Stete, Zip	Code)	The BY			
ment of ant: If It ury or o	JOANN O	JOHNSON	J		409	JEFF	ERS	ON A	JE,	TOWSON MD 21286							
	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, cremetory or other place)  20c. Location - City										n - City or To	own, Stete					
	1 Surial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify)  ARBUTUS MEMORIAL PK 1.0-1.2-00 MARYLA										RYLAN	D					
	21. Signature of Fundal Service Centree 22. Name and Address of Fecility																
	HOWELL FUNERAL HOME											MD	21.20				
	Zia. Fort1. Enter the	disease, or con feilure. List only	plications that	dsed the d	eath. Do not en	4600 LIBERTY HGHTS AVE, BALTO,.											
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month Year **Physician** 6:30 PM ZIMMERMAN SEPH 2000 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PHINS BAYVIEW HOSD. TAI BACTO. 10 If Under 24 Hrs. 8. Data of Birth Min Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Sacurity Number 6. Sex Birthplace (Stata or Foreign Country) **Funeral** Months Days 10 M 20 F 213-30-748 Usual Rasidence of Decedant Director with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits r 28a-f ahov BALTIMORE 18 Yas 2 No Director MD N 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or must be 939 01 NION IJSA ST. 21224 Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) Race - American Indian, Black, Whita, atc. or Nems 11. Marital Status the Medical Examiner filed within 72 hours after 1 ☐ Yas 2 No If Yas, Giva 1 Nevar Married 2 Married 21215-0020 1□ Yes 2□No Specify. þ WHITE 3 ☐ Widowed 4 ☑ Divorced "natural". Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry th and Mental Hygiene.
7 is marked other than traumatic event, the Management. Elamantary/Secondary (0-12) College (1-4or 5+) MANUFACTORY MECHANICAL ENGINEER altimore. Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Surnama) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Hem 27 Ia marked oth-any Injury or other traumatic event Be M. ZIMMERMAN MARGARET SCHODER KNOBLING 2 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ROSEPOINTE WAY SPRING GROVE PA-17362 PERMSH (SisTere ANE 20b. Placa of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) Oct. 16 3 Removal from State BALTO. BAYVIEW (REMATORY 2000 22. Nama and Address of Facility
DELLA NOCE & SONS e of Fune FUNERAL HOME Boto. 2/202 322 S. HiGH 51. complications that causad the death. only one cause on each line. Approximata Intarval Batween Onset and Death Do not antar the mode of dying, such as cardiac or respiratory arrast, Physician /Medical Immediate Cause (Final disease or condition rasulting in death) Examiner Examiner Sequentially list conditions, if any, laading to immediate cause. Entar Undarlying Causa (Diseasa or injury that initieted events rasulting in daath) Last Due to (or as a consequence of): The law requires that the death certificate be axed P.O. Box 68760 Physician/Medical Dua to (or as a consequance of): for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 1 10 No 3 Probably 4 Unknown Records, P 24b. Wara autopsy findings available prior to Be Completed 24a. Was an autopsy complation of causa of death? page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vitai Attending Physician: funeral director. 25. Was casa rafarred to medical examinar? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yas 2 No 2 ☐ ER/Outpatient 30 DOA 1 Inpatiant After this 27. Menney of Death 28d. Dascribe how injury occurred 28c. Injury at Work? 28a. Deta of Injury (Month, Dev Year) 28b. Time of 1 Natural 5 Pending invastigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be 3 Suicida 28a. Place of injury - At home, ferm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and due to the cause(s) and mannar as stated.

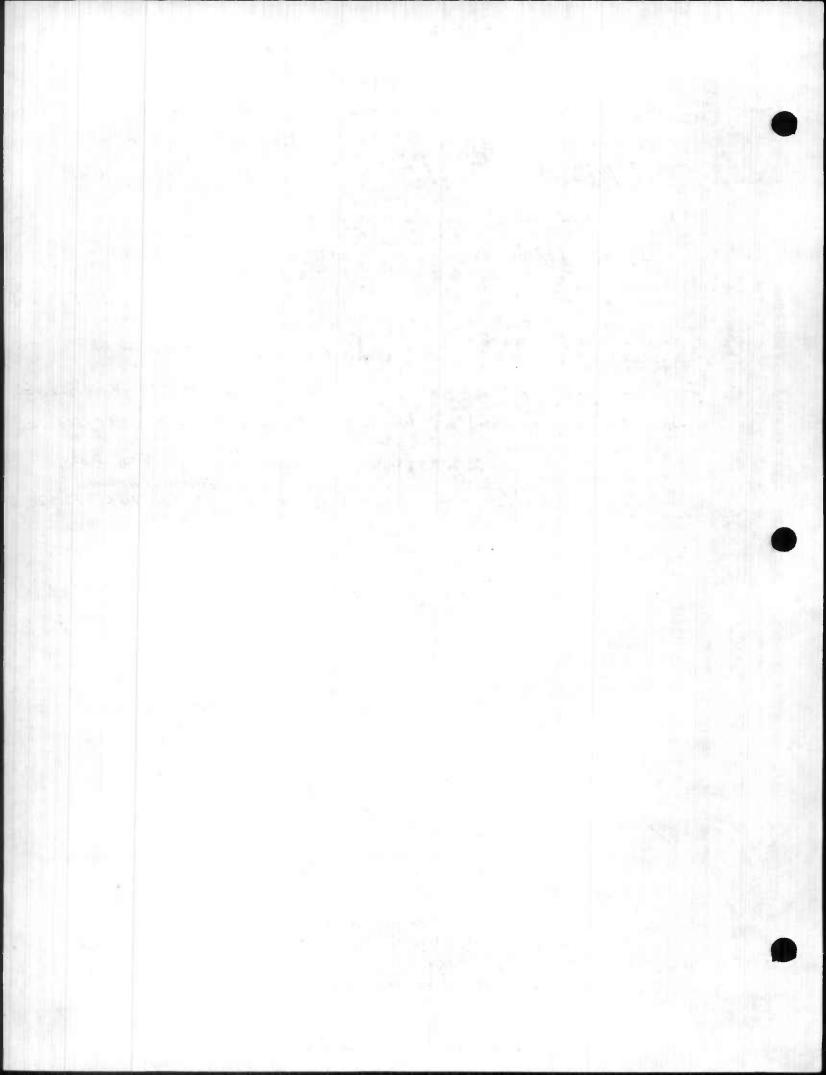
2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mennar stated. 29a. Cartifier (Check only one) W) 29b. Signatore and titla of certifier 29c. Licansa number 29d. Data stoned (Month, Day, Year) 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State

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Registrar

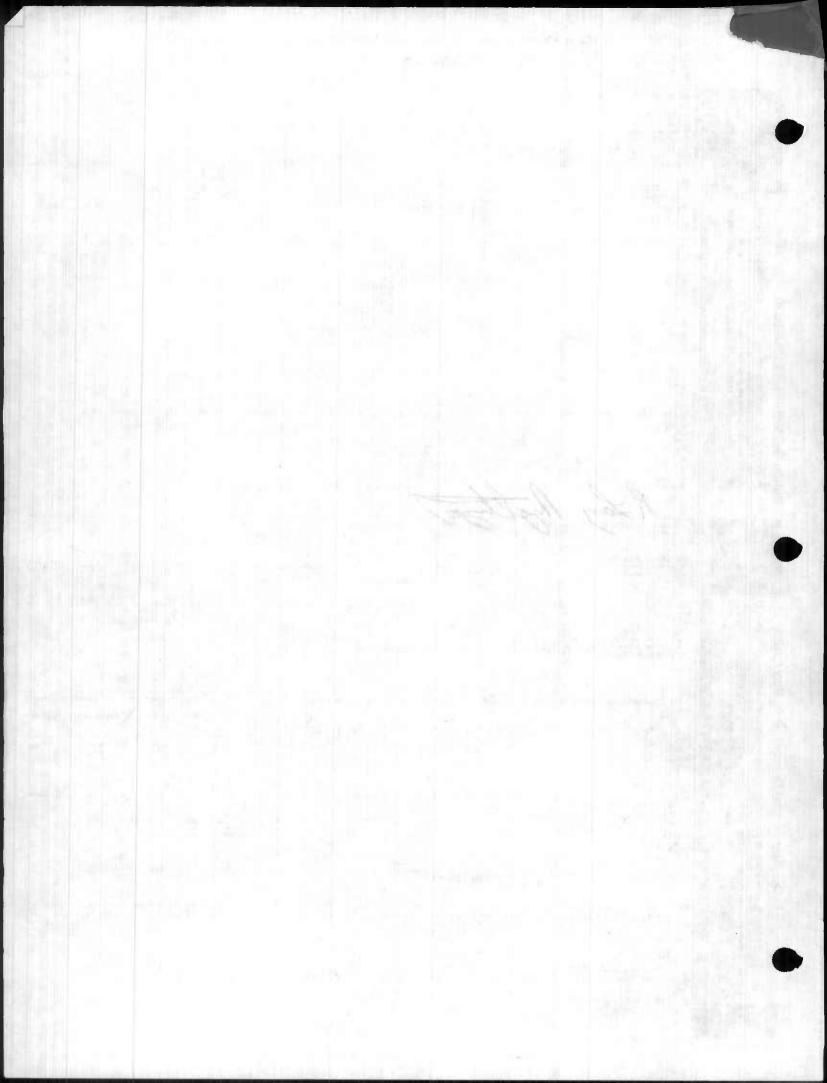
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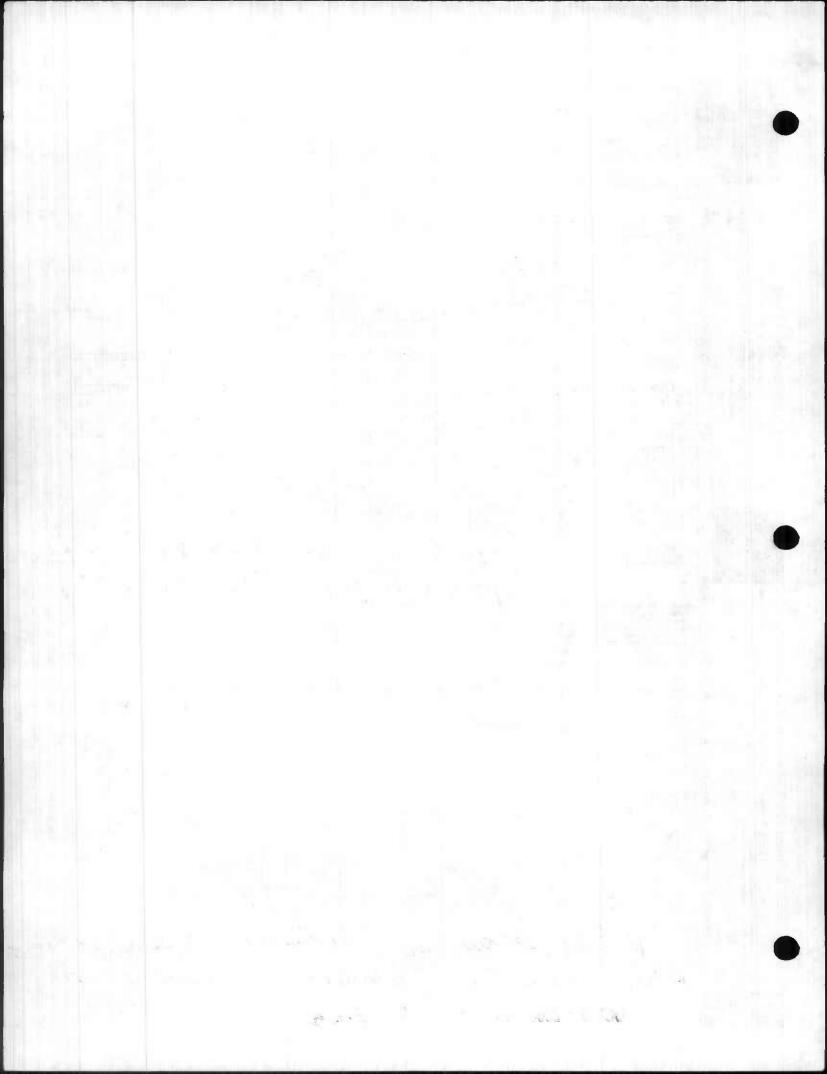
				Certificate	of D	eath		1	Reg. No.	00	02040		
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Examiner	4a Facility Neme (If not institution, g	ive street and number)			4b	. City, To	wn, or Loca	ition of Death		nty of Deeth			
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Funeral Director	5. Social Security Number  050-26-9342  Usual Residence of Decedent	Sex 7. Ag	66 Y	Montha rs.	Days	If Under: Hours	Min.	Date of Birt (Month, Da 12/6/	1 9 3 3	9. Birth Cou NEW	pplace (State or Foreign untry) YORK		
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and be notified at rai Director	10e. Street and Number			10f. Zip C	Code				10g. Citizen o	f What Cou	untry?		
23a o	4146 BLACK ROO	CK RD.		210	074				USA				
r tema 23 direc must funeral	11. Merital Status	12. Was Decedent Armed Forces?	Ever in U,S.	13. Was Decede	ent of His	panic Orig	gin? (Speci	ify Yes or No	14. R	aca - Ameri lack, White	rican Indian,		
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ne traur	19e. Informant's Name/Relationship DONNA KUHN	- DAUGHTE	R 414		K RO						. 21074		
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Important: I any injury o gates.	21. Signature of Funeral Service Licenses 22. Name and Address of Fecility FLETCHER FUNERAL H												
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been signed the should be detected by P									en autopsy ermed?	8	Were autopsy findings available prior to completion of cause		
has pe 2								10	Yes X No		of death?		
director, pa	25. Was case referred to medical examiner?					26. Place	of Death	(Check only o	one)				
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To the Funeral Director: Atter this completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one)  Certifying Physician: To the bast of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stored.  Certifying Physician: To the bast of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stored.									stated. to the cause(s)			
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- 0	1-2. n	C Abst	m	7	7	3:	186	/	91	20/	5		
	30. Name and address of person wh	o completed cause of d	eeth (Item 23a) (	(vpe, Print)	PA	16	FOR	57 m	5/	1/0	0		
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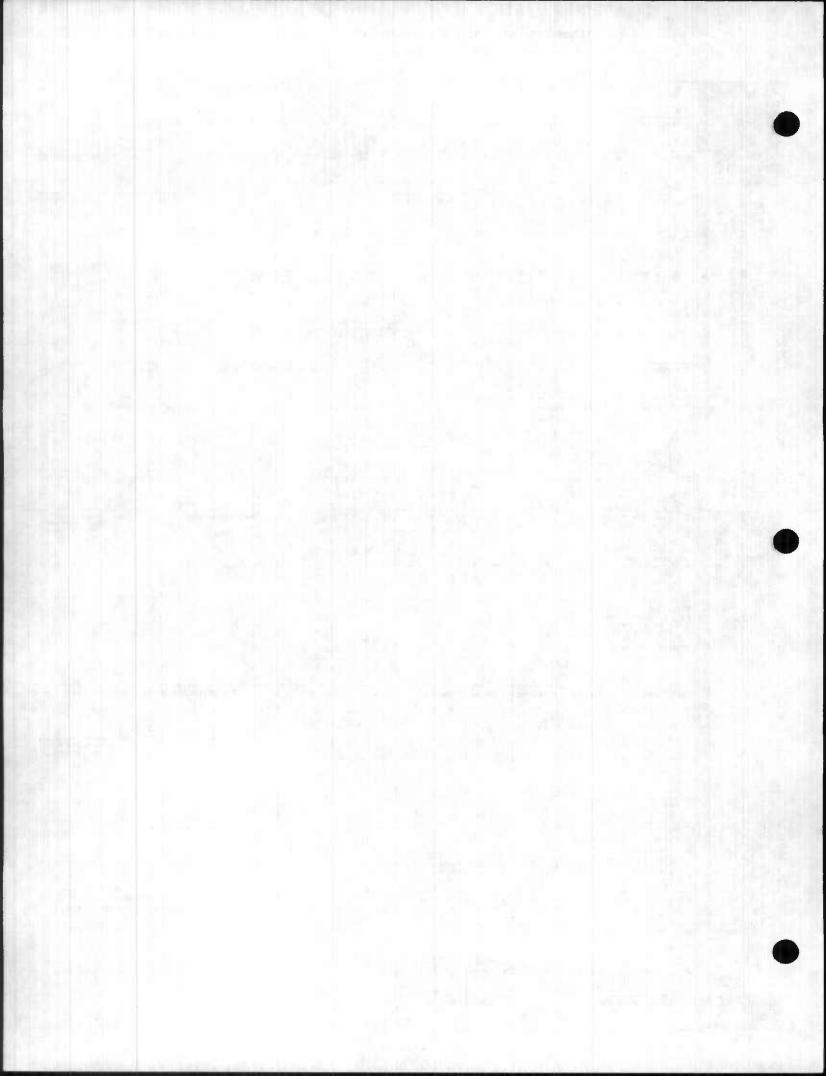
			Cen	tificate of	Death	B	ng. No.	32344				
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Physician /Medical	Joseph Alex	Ayers				Septemb	-					
Examiner	4a Facility Nama (If not institution, giva s	street and number)			4b. City, Town, or	Location of Death	4c. County of D					
	1621 Schucks Road				Bel Ai	r	Нат	rford				
Funeral	5. Social Security Number 6. Sex		last birthday)	If Under 1 Year	If Under 24 Hrs	8. Data of Birth		Birthplace (Stata or Fore Country)				
Director	220-24-6208	M 2 F	71 Yrs.	Months Days	Hours Min	Oct. 17		Virginia				
9	Usual Rasidence of Decedent											
E E S	10a. Stata 10b. County	10c. Ci	ity, Town or Loc	ation				10d. Inside City Lim				
the life	Maryland Harfor	d E	Bel Air					1 ☐ Yes 2 🔀				
or 28s-1 be notifie Directo	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?				
	1621 Schucks Road			210	15			TON				
flare 23 fine must Funeral		2. Was Decedent Ever in U	J,S. 13. W			Specify Yes or No- to Rican, etc.)	14. Race - A	USA American Indian,				
19 5	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	H	Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)	Black, W	Vhita, atc.				
by by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2√2 No	Specify:		Specify:	White				
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"natural edical	(Specify only highest grade		(Give k	ind of work done O NOT use retire	during most of wo	f working 16b. Kind of Business/Industry						
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and and	19a. Informant's Name/Ralationship (Ty)	lumber, City or Town, State, Zip Code)										
127 127	Jeanette M. Ayers / Wife 1621 Schucks Road, Bel Air, Maryland 21015  20a, Mathod of Disposition (Nama of Data 20c, Location - City or Tow											
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in 24 hours he Funeral pletaly filled edical C	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	e, and due to the coursed at the time, do	and due to the cause(s) and manner as stated.  and at the time, date and place, and due to the cause(s)									
within 24 hours of the Funeral Completely filled	29b. Signatura and title of certifier	2	9d. Date signed (M	lonth, Day, Year)								
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10	Perfector  30. Name and address of person who cor  PERFECTO C. VAL	npleted causa of death (Item ALAO, M., D.	17/6	HARTOR	ORD Su,	106 Ffee	570N M)	2047				
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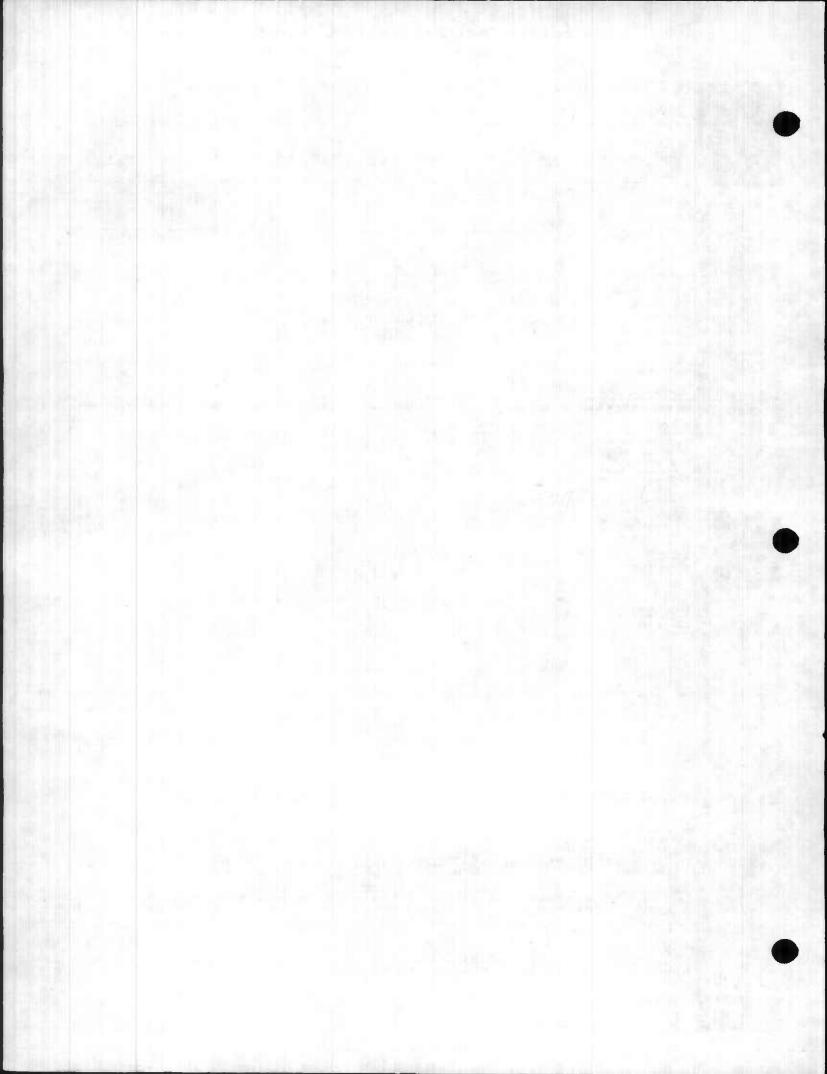
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			1. Decedent's Name	(First, Middle, La	ist)								2. Date of De	Day	Year	3. Tima of Dec	ath
1	Physicia		Dorothy	Lee	ALS	TON								ber 15,		9:50 F	M
	/Medic Examin		4a Facility Nama (If	not institution, giv	e street and nu	umber)				4	b. City, To	wn, or Lo	ocation of Deat				
	EAGITIII	٠,	Garrett (	County M	emorial	Hosi	nital				0	ak1a	and	Ga	rret	t	
-	) <b>5</b>		5. Social Security Nu		Sex		In yrs. last bir	thday)	If Unde	r 1 Year	If Under	24 Hrs.	8 Date of Bir	th		place (State or Fo	oreian
	Funeral Director		251-44-010		1 □ M 2 🂢 F	7		Yrs.	Months	Deys	Hours	Min.	(Month, De	y, Year)	Cour	h Caroli	
Ш	Director		Usual Residence of				1		-		l		верс.	3, 1929	30uL.	ii Caluli	lild
	No. of the		10a. State	10b. County		1	Oc. City, Tow	n or Loc	ation		. 1	4			1	Od. Inside City L	imits
	A day	6	MD	Car	rett		(	Dak1	and							1 X Yes 20	□No
	75 Page 170	Director	10e. Street and Num		1000		•	Jaki	10f. Zi	Code				10g. Citizan of 1	What Cour	otry?	-
	6 8 8	ä							101. 2.		50			rog. Onizari or			
	£ 23	E	Cuppett-We	eeks Nur				1		215				14 Dec	USA	cen Indian,	
	after death with the Maryla or Heme 23s or 28s-f shot stricker mast be notified at	Funeral	11. Maritel Status		12. Was Dec Armed F	orces?	er in U,S.	13. W	Yes, spe	cify Cuba	n, Mexicen	gin r (Sp ), Puerto	ecify Yes or No Rican, etc.)		ck, White,		
20	1 81	by F	1 Never Marrie		If Yes, G	2 ∑ No live		1	☐ Yas	2 🔯 No	Specify:			Specify	y:	Black	
8	72 hours after natural, or it fical Examin	d b	3 Widowed		Year or I	Detes:								101 101 1 10			_
'n	72 met	Completed	(Speci	<ol> <li>Decedent's E ty only highest gr</li> </ol>	ducetion a <i>de completed,</i>	)	16a.	(Give k	ent's Usu	ork done	ation during mosi i)	t of work	ring	16b. Kind of B	usinass/in	dustry	
12	6 5 5 5	d H	Elamantary/Secon	ndary (0-12)	College	(1-4or 5+)					,						
7	Page 1		12 Housewi						wile		10 Metho	de Nom	n (Einet Middle		Home		
Ĕ	ad day	Be	Sam Wade							18. Mother's Name (First, Middla, Maidan Sumame)  Mary Alice McDowell					1		
7	Mark Mark Mile	2															
Maryland 21215-0020	2 sh in mile in mile i	8	19a. Informant's Na											er, City or Town,		Code)	
	and martin		Shiela W.		w/Daugh	ter					Detr	oit,	Michi	~			
910	I to H		20a. Method of Disp	osition Cremation 3 [	Removal from	State	20b. Place of cemeter	l Dispos ry, crem	atory or	me of other plac	e)	i	Dete	20c. Location	City or To	own, State	
Ě	Pages nant of any or o			5 Other (Speci		1 State	Ru	sse1	.1 Ce	mete	rv	19	9/21/00	Winnsbo	sboro, SC		
Baltimore,	Party St		21. Signature of Fur	neral Service Lice	nsee		1-1-1-1	22.	Neme e	nd Addres	ss of Facilit						
8	\$8E58		113.00	oft A of	العا						neral			) (D) (O)	550		
			23a. Part1. Enter the shock, or hear	e disease, or con	plications that	ceused th	e death. Do	not ente	r the mo	de of dyin	g, such as	cerdiac	or respiratory	prrest,	550	Approximate	
1	Physician		snock, or near	t failufa. List only	ona cause on	each lina.									1	Interval Between Onset and Dea	en ith
	/Medical		Immediete Cause (F		n										1		
	Examiner		disease or condition rasulting in death)		a. Pn	eumo									1.	Days	
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	ifficate be executed g physician and as the burial-transit	edicai Examiner			b	Di	ue to (or as a	0000000	10000 01			-			1		
,	certificate be executionally and the properties as the burial-trans	Exa	Sequentially list con if any, leading to im- ceuse. Entar Under	mediate		00	ie to toi as a	corisequ	Jenice Oil								
68760,	slcia bur	<u>e</u>	Cause (Disease or i	njury	C	D.,	- 10 /07 00 0										
98	phy s the	ğ	resulting in death) L	ast		Du	e to (or as a	consequ	ience oi).								
×	Se di se	3			d												
Bo	death e atter	Clar															
o.	p eq	Physician	Part If. Other algniff	cant conditions	contributing to	death but r	not resulting in	n the un	derlying	cause giv	en in Pert I					o the cause of d	
۵.	ires that the death or signed by the atten d be detached for u		Renai	l Failur	e								10	Yee 2 No	3 Pro	bably 4∭Uni	known
Records,	sign a b	1 by											040 18/04	an autopsy	24h W	era autopsy find	inas
0	v requires been sign should be	etec											parf	ormed?	91	veilable prior to	
ec	aw 2 S	d	71.9			P-1					-					death?	
	E ag	Completed											1 🗆	Yes 2⊠No	1	☐ Yas 2☐ No	
Vital	Physician: The I this certificate haral director, page	Be										of Dea	th (Check only	ona)			
of	Physic this ce	2	1 ☐ Yas 2 💢 N	No	Hospital:	Inpatient	2 ER/O	tpatient	3□ D	OA Oth	er: 4 Nu	ursing He	ome 5 Ras	idance 6 Ott	nar (Speci	fy)	
	neral		27. Mannar of Death 1 DNatural	5 Pending	28a. Date (Mo	of Injury		Time of		28c. Injur Wor	y at k?		28d. Dascribe	how injury occu	rred		
0	Attending or death.	atic	2 Accident	Investigation	n				М		Yes 2	No					
Division	Att of de by the	E E	3 ☐ Suicide 4 ☐ Homicida	6 Could not be	209. Plac	e of Injury	- At home, fa	rm, stre	et, facto	y, office				(Street and Num. wn, State)	ber or Aur	al Route Number	Γ,
	al Or De in De in	Certification:												,,			
	hour hour ly fill								curred at the time, date and place, and due to the causa(s) and				causa(s) and m	annar as	stated.		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical							i, in my o	pinion, dea	un occur	emii eni is per	date and piece,	and due t	o me cause(s)	- 1	
	withi To th	Ž							e number 29d. Date signed (Mont				ed (Month,	Day, Year)			
			D23979								9/16/	00					
	1	1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								., 237						
	5		Dr. Rober							t	Oakla	nd	Maryla	nd 215	50		
	Sta	te.	31. Date filed (Month		1		Signature	Jul	-11 0	,	Jakta	iiu,	riar y rai	.rd 213	50		
	- Ota			CED 1 0	2000	Mrs.	asker!	14		100	11						



State of Maryland / Department of Health and Mental Hygiene 00 32546

				Ce	ertificate of	Death		Reg. No.				
		1. Decedent's Nama (First, Middla, Li	ast)	ET BILL			2. Data of De		Vaar	3. Tima of Death		
	Physician	Ronnie Evere	Septem	ber 22,	2000	3:15 PM						
	/Medical Examiner	4a Facitity Nama (If not institution, gir		LD, Sr.		4b. City, Tow	n, or Location of Deat	-				
	LAdillilici	28 Apache Trail				Oal	cland	Ga	rrett			
-	Funeral	*	Sax 7. Aga	(In yrs. last birthda	y) If Undar 1 Yaar	If Undar 2	4 Hrs. 8. Data of Bi			elaca (Steta or Foreign		
	Director	234-78-8612	1⊠M 2□F 50	Yrs.	Months Days	Hours	Min. (Month, D.	3, 1949	West	Virginia		
		Usuat Rasidence of Decedent				<u> </u>		.,				
	yland	10a. Stata 10b. County	1	I0c. City, Town or	Location				10	0d. Insida City Limits		
	Mer To	MD Garr	ett	Oal	cland					1 X Yas 2 □ No		
	with the Me a or 28a-f a be notified	10e. Street and Number			10f. Zip Code			10g. Citizan of	What Coun	itry?		
	3a o	28 Apache Trail			2	21550		US	A			
	w items 23sminer must	11, Marital Status	12. Was Decedant Ev	ar in U,S. 13	. Was Decedant of I	lispanic Origi	in? (Specify Yas or N		e - Amarica	an Indian,		
	r ther driver	1 Nevar Married 2 Married	Armed Forcas? 1 X Yas 2 □ No		Il Yas, specify Cub	an, Maxican,	Puarto Rican, atc.)	Bta	ck, Whita, a	atc.		
21215-0020	0	3 ☐ Widowed 4 ☐ Divorced	1 ⊠ Yas 2 □ No If Yas, Giva Yaar or Datas: V	ietNam	1 ☐ Yas 2 ☒ No	Specify:		Specify: White				
9	"natura	15. Decedant's E	ducetion	16a. Dao	edant's Usual Occup	pation		16b. Kind of Business/Industry				
215	ed within 72 ho ygiene. wr than "naturn it, the trades. Completed	(Specify only highast gr	(Specify only highest grada complated)  Elementery/ condery (0-12)  Collega (1-4or 5+)  Chh  Collega (1-4or 5+)  Produce Manager						king			
212	iene iene	2th		Grocery Store								
	be filed dother of other went, by Be Co	17. Fathar's Nama (First, Middla, Las	1)			18. Mothar	s Nama (First, Middle	ma (First, Middla, Maidan Surnama)				
an	Mentel Me	Darl Everett	Arnold			Marga	aret A	t Alice Pine				
Maryland	2 should be filed within 72 hours is and Mentel Hygiene.  is marked other than "natural, raumatic event, the Media Entrangement of the Completed by	19a. Informant's Name/Retationship	(Type, Print)	19b. Ma	iling Address (Straat	and Number	or Rural Routa Numb	per, City or Town,	Steta, Zip	Code)		
M	permit. Pages 1 and 2 should be filed within Department of Health and Mentel Hygiene. Important: if item 27 is marked other than 1 mark injury or other traumatic event, it is more.  To Be Compl	Sharon S. Arnold					akland, Ma		21550			
e,	Health Health John 27	20a. Mathod of Disposition	,	20b. Place of Dis	position (Nama of		Data					
Baltimore,	permit. Pages Department of I Important: If ite any injury or of phose.	1 Burial 2 Cramation 3			amatory or othar pla	10/05/00	17	D	1171			
Ħ	ortani njun	4 Donation 5 Other (Special			ent Cemete	4		25/00 Horseshoe Run, W				
Ba	Depa mpo my la	21. Signatura of Funaral Sarvice Lice	11566	22. Nama and Addrass of Facility Stewart Funeral Home								
	20200	13 added 17 x	DAPPE		1550							
	_	23a. Part1. Entar tha dispasa, or con shock, or haart lailura. List only	nplications that causad the rona causa on aach line	na daath. Do not a	ntar tha moda of dyi	ng, such as c	ardiac or raspiratory	arrast,		Approximata Intarval Batwaan		
	Physician									Onsat and Death		
	/Medical Examiner	tmmediata Causa (Final disaasa or condition	sarco	idosis					1 3	years		
85		resulting in deeth)	Di	ua to (or as a cons	aquance of):				1			
	e e											
	death certificate be executed e ettending physician end ed for use as the buriel-trensit	Sequentially list conditions,	Di Di	ue to (or as a cons	equence of):				1			
0,	ian e uriel-	Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarlying Ceuse (Disease or injury that initiated events										
68760,	entificate be ling physicie se as the bu	that initiated evants rasulting in death) Last	C	a to (or as a cons	equance of):				1			
9 3	ng p								1			
Вох	th ce lendi		d									
J. E	0 0 0	Part II. Other eignificant conditions	contributing to death but	not resulting in the	underlying ceuse giv	ven in Pert I.	23b. Did	tobacco uae co	ntribute to	the cause of death?		
P.0	by the stacked ache	P) - 11 12 7 - 12 13					10	Yee 2N No	3 Prot	bably 4 Unknown		
	= 00											
Records,	been sign should be						24a. Wa	s an autopsy ormed?		are autopsy lindings aitabla prior to		
0	iaw requires been s 2 shoul							OIIII GG	COL	mpletion of ceusa death?		
R	0 - 5						10	Yas 2 No	10	∃Yas 2□ No		
	certificete rector, pag	25. Was cesa ralarred to medical	1			26 Place	of Death (Check only			3140		
5		axaminer? 1 ☐ Yas 2 ☒ No	Hospitat: 1 ☐ Inpatiant	2 ☐ ER/Outpati	ent 3 DOA Oth	Jar.			ner (Specifi	(A)		
	Physical distriction	27. Manner of Deeth	<u> </u>		1		sing Home 5 X Res	how injury occur		//		
no	After funer	1 Netural 5 Panding invastigation	28e. Deta of Injury (Month, Day )	<i>'ear)</i> Injury		rk?  Yas 2.∐N						
S	deat deat ctor: y the	3 Suicida 6 Could not b	OPa Diago al Inium	- At home larm				(Street and Numi	ber or Rura	al Routa Number,		
Division	tal or Attending P rs after death. al Director: After i ed in by the funer: Certification:	4 Homicide detarmined	28a. Place ol Injury - At homa, larm, straat, factory, offica building, etc. (Specify)					wn, Stata)				
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune completely filled in by the fune Medical Certification	29a. Cartifiar 11 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end menner as stated								tated		
	in 24 hour he Funer pletely fill edical		miner: On the basis of ex	xamination and/or								
	Me Me	29b. Signatura and titla of certifier	1/		29c. Licans	sa number		29d. Data signe	ed (Month.	Day, Year)		
	F ≱ F 8		11									
			D15333 9/23/00									
4	ALVA	30. Nama and addrass of person who					Co Giller					
0	4 ( , ,	Dr. Thomas Johns		311 N. Fourth St., Oakland, Maryland 21550								
	State	31. Data fited (Month, Day, Year)	32. Registrar's	s Signatura	4 las	1/1						
	Registrar	357 20	LUUU Promp	^	· MANDER	ALC:						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Day **Physician** Adams, September
4b. City, Town, or Location of Death 4c. 24, Ernest Thomas 2000 /Medical 7:00 PM 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner 19071 Flat Iron Road Valley Lee Mary S
9. Birthplece (Stete or Foreign Country) If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dev. Year) **Funeral** Months Deys Hours Min 1⊠M 2□ F Yrs. 217-36-9277 Director March 29, 1929 Maryland Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or flams 23s or 26s-f short 1 ☐ Yes 2 ☑ No Directo Maryland St. Mary's VAlley Lee 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 19071 Flat Iron Road 20692 USA Funeral 14. Raca - American Indien, Black, Whife, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify à 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Farmer 12th Grade copatiment of Health and Mental Hy important: If Health and Mental Hy any injury or other trausment other other. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Mary Henrietta Booth Thomas Adams, Sr. Ernest 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) General Delivery, Drayden, Maryland 20630 Louise E. Adams (Spouse) Saltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 20e Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete St. Cearge's Catholic Cemetery 9/27/2000 4 ☐ Donetion 5 ☐ Other (Specify) Valley Ise, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility.
Mattingley-Gardiner Funeral Home, P.A. pardine Kliack P.O. Box 270, Leonardtown, Maryland 20650 Pert . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) P.O. Box 68760. attending physician Due to (or es e consequença of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the the 1 Yes 2 Ale 3 Probably 4 Unknown been signed by Division of Vital Records. à page 2 should be 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? Be Completed 2000 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: 25. Wes case referred to medical 26. Place of Death (Check only one) t Yes 2 Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home To 5 Residence 6 Other (Specify) this 28e. Dete of Injury (Month, Dey Year) Certification: 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Naturel
2 Accident 5 Pending investigation after death.

Director: Aft
d in by the fur 1 Yes 2 No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Discompletely filled in 1 Serutiving Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es stated.
2 Medical Examiner of the best of exemination end/or investigation, in my opinion, death occurred et the time, dete end pleca, end due to the ceuse(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of 29c. License number 29d. Dete signed (Month, Dey, Year)

State Registrar

SEP 2 7 2000

dames C. Boyd,

31. Dete filed (Month, Dey, Year)

30. Name and address of persop who completed cause of deeth (Item 23a) (Type, Print)

32. Registrer's Signeture

California, Maryland 20619

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State of Maryland / Department of Health and Mental Hygiene

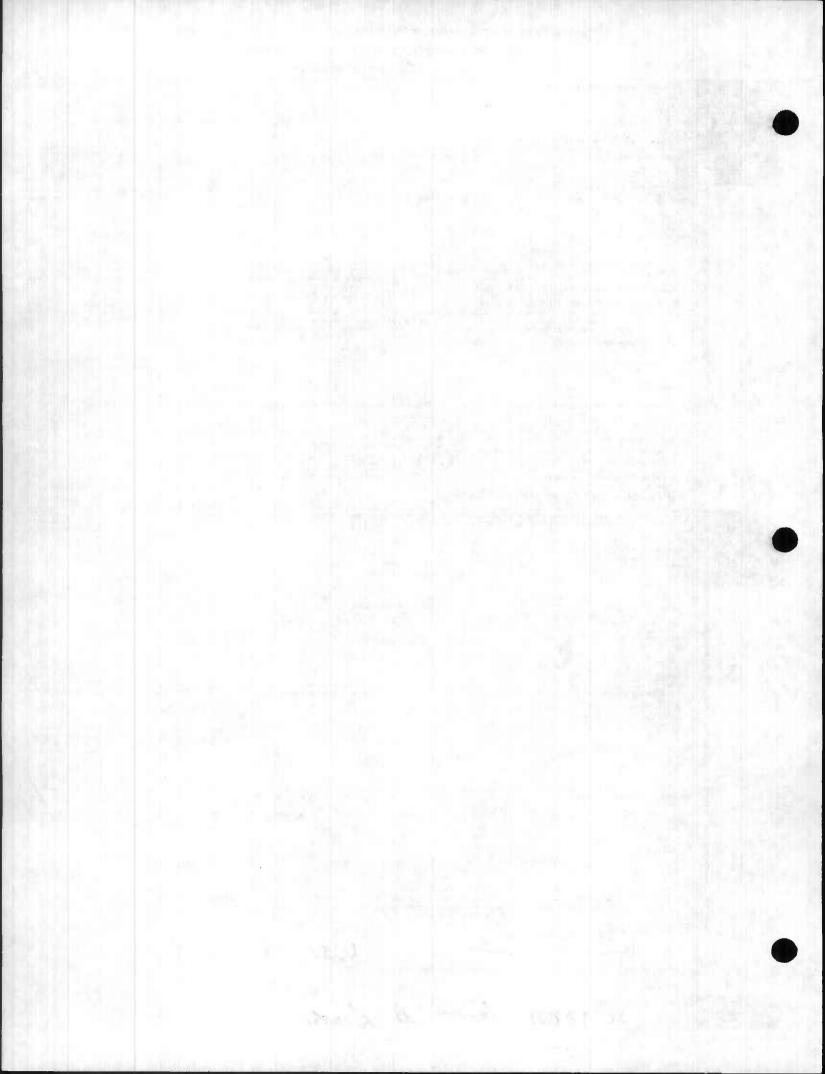
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						Certific	ate of	Death		Reg. No.	00	040	
		_	1. Decedent's Neme (First, Middle, L	ast)				el light	2. Dete	of Death h Dey	Year	3. Time of Deeth	
ec.	Physician /Medical	_	Anna Mae	Aud							,2000	1:10 a.m.	
	Examine		4e Facility Neme (If not institution, g	ive street and number)				4b. City, Tow	n, or Location of		unty of Dee		
			20697 Chingvi	lle Road					nardtown			Mary's	
	Funeral	1	5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last l	Mont	hs Deys		Min. 8. Dete	of Birth th, Dey, Year)	9. Bir	thplece (State or Foreign ountry)	
	Director		216-22-3476	IUM ZEF	72	Yrs.				20, 192		yland	
	D .	-	Usuel Residence of Decedent  10a. State 10b. County		10c City To	wn or Location						10d. Inside City Limits	
	aho sho											1 ☐ Yes 2 ☐ No	
	or 28a-fa	5	Maryland St. M.  10e. Street and Number	ary's		Leonar	d COWN			10g. Citizen	of What C	ountry?	
	ath with the Marylar 23a or 28a-f show Let be northed at					101.							
	iter death with the Maryland r thems 23s or 28s-f show inserporal be northed at	e a	20697 Chingvi	LLe Road  12. Was Decedent	Ever in 11 S	13 Was De	206		in? (Specify Yes	Unit	Rece - Ame	tates erican Indien,	
		5	1 Never Merried 2 Married	Armed Forces		If Yes,	specify Cut	en, Mexican,	in? (Specify Yes Puerto Rican, et	c.)	Bleck, Whit		
)20	9 0 9	à	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Detes:		1□ Ye	s 2 No	Specify:		Sp	ecify: W	White	
5-0020	n 72 hours naturel'.		15. Decedent's		16	Sa. Decedent's l	Jsuel Occu	pation		16b. Kind	of Business	/Industry	
215	5	Сощрівте	(Specify only highest g	rade completed)  College (1-4or	E.\\	(Give kind of life. DO NO	work done Tuse retire	during most	of working	rking			
2121	d within plene. r then	E	12	College (1-40)		ayroll	Super	visor		US C	Govern	ment	
	be filed tel Hygi d other event, p		17. Father's Neme (First, Middle, La:	st)				18. Mother	's Neme (First, A	fiddle, Meiden Su			
lar lar	Mentel Hygi Mentel Hygi arked other atic event, I	Anthony DeSales Delozier Nettie Elizabet								beth Cul	lison	1	
Maryland	d 2 should be filed within and Mentel Hygiene. 7 Is marked other than treumatic event, the Mentel Hygiene. To Re Comm		19e. Informent's Neme/Reletionship	(Type, Print)	15	9b. Meiling Add	ress (Stree	t end Numbe	r or Rurel Route I	Number, City or To	own, Stete,	Zip Code)	
-	and salth		Benedict I. Aud	d / Husband	2	0697 Ch	ingvi	lle Ro	ad, Leor	ardtown,	Mary	land 20650	
<b>Baltimore</b>	ges 1 end t of Health if Nem 27 or other ti	1	20e. Method of Disposition		come	of Disposition (	(Neme of or other ple	ece)	Dete	20c. Locat	ion - City or	r Town, Steta	
Ē	Peges net of int: if h		1 Buriel 2 ☐ Cremetion 3 4 ☐ Donation 5 ☐ Other (Special Control Cont			Face C	emete	rv	9-28-0	0 Great	Mills	, Maryland	
a	Semit. Peg Sepertment mportant: I iny injury o		21. Signature of Funeral Service Lic	ensay -				ess of Facility	1			Home, P.A.	
0	Ped Ped		Mary B. Rizzo	17/320	01114	22055	¥011	hoorus				20650-0279	
	-	1	23e. Pert1. Enter the disease, or co shock, or heart failure. List on			o not enter the	mode of dy	ing, such es o	cardiec or respire	tory errest,	/II , FID	Approximete	
	Physician		snock, or near railure. List on	y one cause on each I	ine.			- 1	7			Intervel Between Onset end Death	
20	/Medical		Immediate Ceuse (Final disease or condition	F	1. 100	MAN	ut	21	1105	-		mo	
	Examiner		resulting in deeth)	8.	Que to (or as	a consequence	41	u	-			10	
_		9		/	an	nen	w	ral	odel	200		months	
	physicien end s the buriet-transit	2	Sequentially list conditions,	0	Due to (or as	a consequenção	of):	-	- 4				
0			Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	1	un	164	2n	AQ)	2 -			140	
68760	deeth certificata be attending physicie of for use as the but its lan Mantical	200	that initieted events resulting in death) Lest	6.	Due to (or as	unsequence	of):					11	
9	E 0 6	5			1							U	
Box	at the deeth cer d by the attendir etached for use	2	MELL AND	d		/							
	he at he at	310	Pert II. Other significant conditions	contributing to deeth b	out not resulting	in the underlyi	ng cause g	iven in Pert I.	231	. Did tobecco us	s contribut	ta to the causa of death?	
P.	ed by the detache									1 <b>8</b> Yes 2□	No 3□F	Probably 4 Unknown	
Ś	the open	2											
ecords,	The law requires ate has been sign page 2 ahould be	3							24a	. Wes en autopsy performed?	24b.	. Were eutopsy findings evailable prior to	
9	has be	2										completion of cause of death?	
Œ	The la	5								1   Yes 2   1	No	1□Yes 2□No	
Vital	certificate rector, pag		25. Wes case referred to medical exeminer?					26. Plece	of Death (Check	only one)			
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0 0	endir seth. or: A the fu	200	2 Accident investiget	on		М	1[	Yes 2 n					
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0	in series												
	To the Hespital or Attending Physician 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Madical Certification:	2	29a. Certifier  (Check only   Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner es stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end plece, and due to the ceuse(s)										
	thin 2	00	one)	end menner st	eted.		oos Lissa	an aumb an		ood Date	ioned (Man	off David Mana)	
			29b. Signeture and the of certifier	2111/2	1/-	-110	250. LICOT	se number	1119	290. Dele s	1/	oth, Dey, Year)	
			XIMIL	4 V the	WIZ	NEW)	d	1/6	tl/	1 "	100	00	
(5)		1	30. Name and address of person wh	11					-				
10)	de		J. Patrick Jarb			Three No	otch 1	Road, 1	Hollywoo	d, Maryl	and 2	0636	
	State Registrar		31. Dete film (Month, Dey, Year) SEP 2 7	2000 32. Regist	rer's Signeture	6	Soon	1.					
	negistidi		OFL W	2000	-	10.	KINUL	CV.					

DHMH 16 Rev 6/95

	1344			(F. A. A. L.		of Maryl		Certification Certification		Death	Mental Hy	Reg. No.	0 (	32549	
3	Physicia /Medic	n	1. Decedent's Name	atherine		Abell					Septer	mber 15,	2000	3. Time of Death 10:55 PM	4
	Examino Funeral Director		St. Mar St. Mar 5. Social Security Nu 219-72-25	y's Nurs		nter	yrs. last bir	thday) If Un Monti	der 1 Year	4b. City, Town, or Leonardt If Under 24 Hrs Hours Min	own	,	Mary'	S ace (State or Foreign Tyland	,
		-	Usual Residenca of	Decedent 10b. County		100	City Town	n or Location						Dd. Inside City Limits	_
	Maryla 4 sho		Maryland	St. Ma	rv's	100		llywoo	đ					1 ☐ Yes 2X No	
	eth with the Marylan s 23a or 28a-f show	5	10e. Street and Num			Road		10f.	Zip Code 20636			10g. Citizen of W U.S.A.	Vhat Count	ry?	
020	or Herra	by Funeral	11. Marital Status  1 □ Never Merrie  3 ☑ Widowed	1.10	12. Was Dec Armed F 1  Yes If Yes, G Year or I	orces? 2 🖾 No ive	in U,S.		cedent of F pecify Cub	dispanic Origin? (5 an, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	o- 14. Race Blec Specify	e - America k, White, e		
21215-0020	within 72 hours one. than "natural",	Completed		15. Decedant's Enfy only highest grand	ade completed)	) (1-4or 5+)	16a.	Decedent's U (Give kind of life. DO NO Homem	work done Tuse ratire	during most of wo	orking	16b. Kind of Bu	usinass/Ind		
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ary	AS DE E	0	19a. Informant's Na				19b	. Mailing Addr	ess (Street			ber, City or Town,	State, Zip	Code)	_
ē,	Haalth Harn 27 other tr	-	Mary E. B	osition		20	b. Place of	915 Lat Disposition (a y, cramatory)	Vame of		Road, I	Hollywood 20c. Location -			53
im	Pages ment of ant: If Its ury or o			Cremation 3 5 5 Other (Special		State				Cemetery	9/20/2000 Hollywood, Maryland				
Baltimore,	permit. Pages Department of Important: If It any Injury or pnce.		21. Signature of Fur	ael K	Gard	liner	,	Matt	ingle	-		ral Home		0650	
	Physician		23a Part Enter th shock or hear	e disease, or com failure. List only	plications that one cause on	caused the each line.	death. Do	not enter the n	node of dyi	ng, such as cardia	c or respiretory	errest,		Approximeta Interval Between Onset and Deeth	
	/Medical Examiner		Immediate Cause (F disease or condition resulting in death)	inal	a. Caro	**		y Arre		l-XZD					
		Je			Gene			tv and		dration				2 months	
8760,	death certificate be assecuted attending physicien and of for use es the burial-transit	al Examiner	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or in	ditions, nediete lying njury	0.	Due	to (or as e	consequence	of):	e Demeti	a)				
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			) (	-					DOS	51738	>	9-18	7-00	3	
	prof	30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)  Kae T. Aung, MD Hollywood, Maryland 2063								36	7 1 1				
	Stat Registra	5	31. Date filed (Montf	EP 192		Registrar's S	signature	B	loon	6					

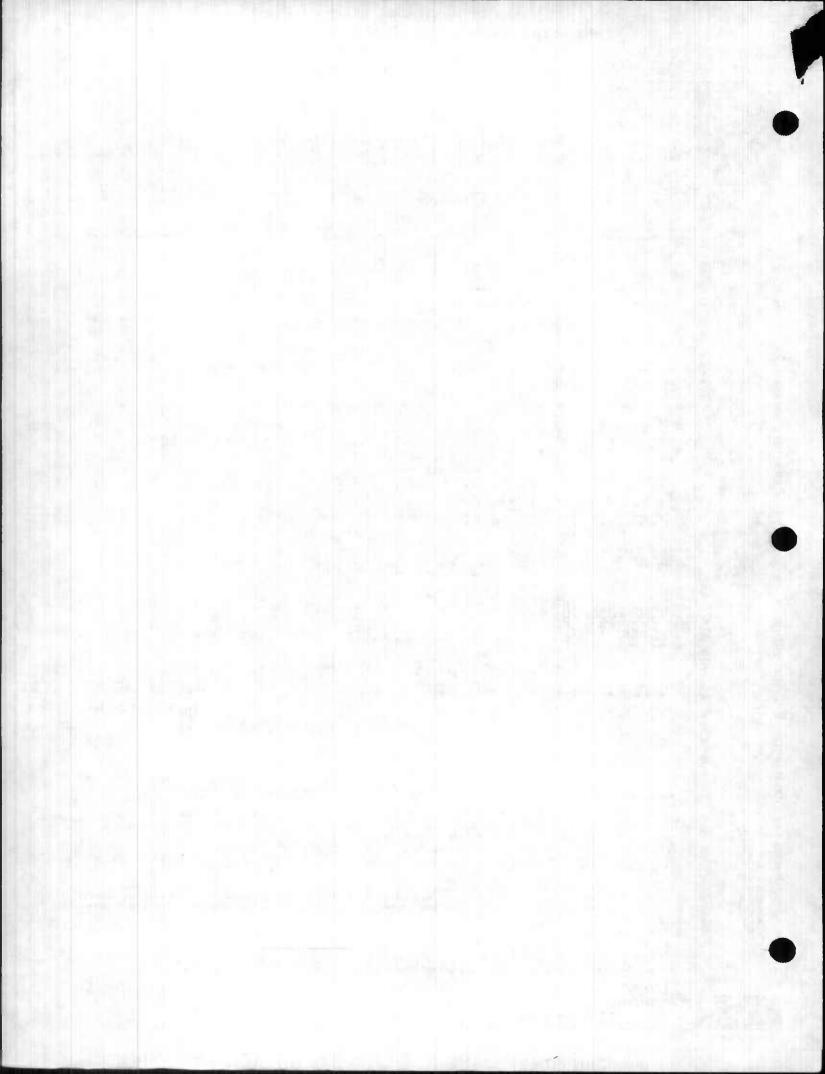
DHMH 16 Rav 6/95



Amend Item 12, per F.D., 10/05/2000, Carroll County, wil Piease Type or Print in Biack indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 29c, per Phy. 10/02/2000, Carroll County, wil Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** AM cluin 25, 2000 4c. County of Death Stotember /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street/end number) Examiner of MARY/AM Baltimore City Baltimore Inwersety redica, If Under 1 Year | If Under 24 Hrs. (In yrs. last birthdey) 6. Sex 10 M 20 F 8. Date of Birth
Jan 17 9. Birthplece (State or Foreign Country) Maryland Social Security Number 7. Age Year 1918 **Funeral** Days Min 115-09-0944 Director Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Carroll Director Svkesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6309 Candlewick Court 21784 Funeral USA death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spacify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify Specify: White þ 3 Widowed 4 Divorced WWIT "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Administrator Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Mental Peges 1 and 2 should be ie marked o Edward Beall Cora R. Beall 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Intormant's Name/Reletionship (Type, Print) permit. Peges 1 and 2: Department of Health er Important: If Item 27 ie any Injury or other treu Mrs. Pauline A. Beall (Wife) 6309 Candlewick Court Sykesville, MD 21784 ca of Disposition (Neme of Date 20c. Location - City or Town 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Placa of Disposition (Name of camelery, cremetory or other place)
All County Cremation Srv. 9/26/00 Sykesville, MD 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) 21. Signature of Funeral Service Licensee Brian 0 Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one ceuse on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence ot): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be execut as the buriel-tran Due to (or as a consequence ot) P.O. Box 68760 Due to (or as a consequence of): detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown à of Vital Records, Be Completed by page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? has 2 NO 1 Yes 1 ☐ Yes 2 ☐ No this certificate the funeral director, 25. Was case reterred to medical examiner? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Unpatient Medical Certification: To 2 ER/Outpatient 3 □ DOA 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Division Netural 2 Accident 5 Pending 1 Yes 2 No after deeth. investigetion 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital e within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) and manner as stated.

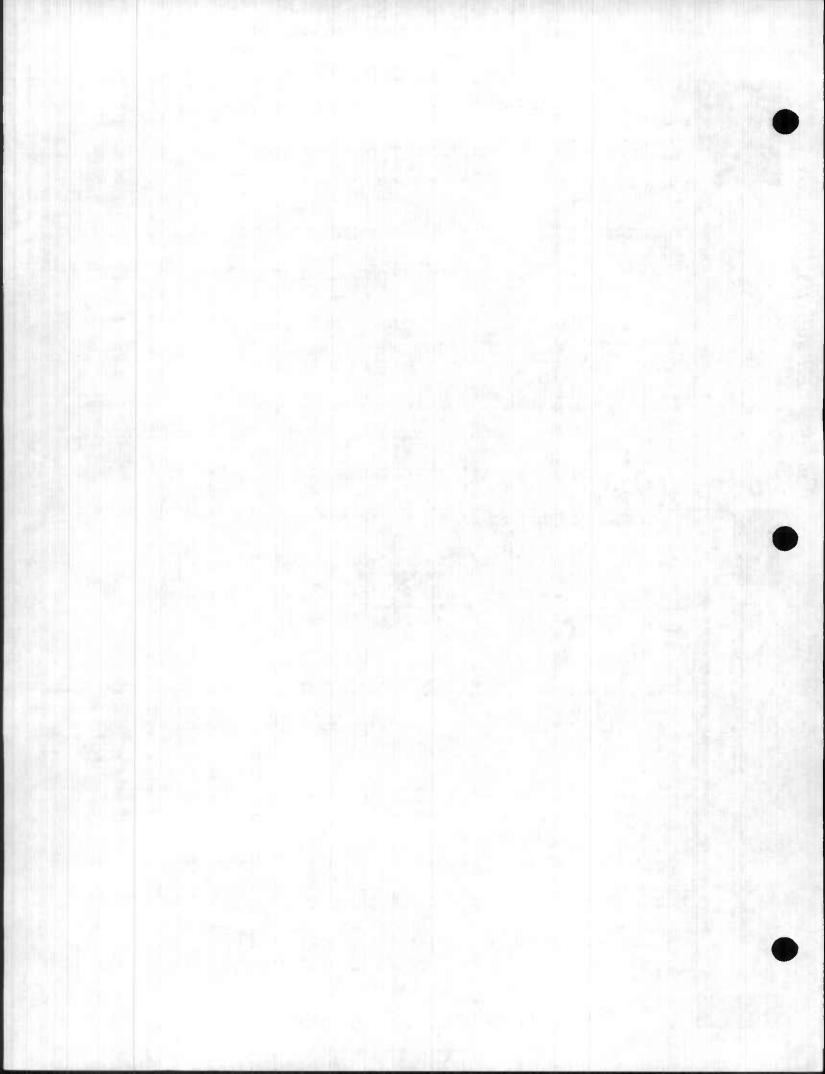
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end placa, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) P14654 30. Name and address of parson who completed cause of death (Item 23a) (Typa, Print) South Jorge 2 141 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State Registrar 0 2 2000 DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

			C	ertificate of	Death		Reg. No.	0 0 0 0 0 1				
Physician		Last) ELIZABET	Н	BARN	ES	2. Dete of De Month SEPTEM	ber 282	Yeer 2 000 2 00 A				
/Medical	An English Mamo //fines institution a	niva street and number)			4b. City, Town, or							
Examiner			HOGDIM		WESTMI	NSTER		ROLL				
	5. Social Security Number 6		e (In yrs. last birthda						eian			
Funeral Director	217-07-8711	1□ M 2√2 F	87 Yrs.	Months Deys	Hours Min	8. Date of Bi (Month, Do	1913	9. Birthplaca (Stete or Fore Country) MARYLAND				
Du B.	Usuel Rasidanca of Decedant  10a, Stete 10b, County		10c. City, Town or	Location				10d. inside City Lim	nits			
or 28s-f sho be notified a	MD. CARRO	LL	WESTMI		176			1 □ Yes 2½				
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				2115	7		USA					
flor death of the flower than 23 singer must	11. Maritel Status	12. Was Decedent Armed Forcas?	Ever in U,S. 1	3. Was Decadent of I	Hispanic Origin? (S	Specify Yes or No		a - Amarican Indien, k, White, etc.				
DZO un attor inf., or th Examina				1 ☐ Yes 2 No		To Filoari, ato.,	Specify					
		Education	16a. De	cedent's Usuel Occu	pation		16b. Kind of Bu	usiness/Industry				
nd 21215-0 be fised within 72 ho list Hygiene. Johns then 'netur went, the Medical.	(Specify only highest of	grade completed)	(Gi	ve kind of work done  . DO NOT use retire	during most of wo	orking						
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E a set y	4 Donetion 5 Other (Spe		WESTMIN					INSTER, MD.				
Depart Depart Import Import Import Import	21. Signature of Eunettal Service Lic	cansee	2	22. Name end Address 54 E. MA				AL HOME ,MD. 21157				
	23e. Pert1. Enter the disease, or co	amplications that cause						Approximete	-			
	shock, or heart feilure. List on	ty one cause on each li	ne.	, , , , , , , , , , , , , , , , , , ,				Intervel Between Onset and Death				
Physician /Medical	immediate Cause (Final	1-	5	/	1 1 7	1-1						
Examiner	disease or condition resulting in death)	a. Mo	uc u	repha	dopal	ly		<u> </u>				
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asit ed		b. Haute	indo	CATEDIA	2 100	MAILC	110 N					
68760, ficate be executed physician and is the burial-trensit	Sequentially list conditions, if any, leeding to immadieta		Dua to (or as a con-	sequanca of):								
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x 68/60 ertificate be ling physicial se es the burl	that initiated events resulting in death) Lest		Due to (or es e cons	sequenca of):								
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v require							omed?	evaileble prior to completion of cause	_			
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o Ph fer th nereit		28a. Dete of Inju (Month, De	y Year) 28b. Time		ury at ork?	28d. Describe	how injury occur	red				
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DIVISION C belor Attending P is after deeth. at Director: After t led in by the funeral	4   Nomicoe	bullding, et	с. ( <i>эрөспу)</i>			Only of Te	Juni, Ototoj					
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Mec Mec	29b. Signature and vitte of certifier	end menner st	atou.	29c. Licen	se number		29d. Date signe	d (Month, Dey, Year)				
F. 1 E S	NA	MD		0		5	SECTION	IBER 28,20				
	0		A-1.		2	1-1-	301767	21/20	0			
	30. Name and eddress of person wh	o completed cause of c	leath (Item 23a) (Typ	pe, Print) 200	Memorial.	C COLSO	minster,	21157 SPITAL-M.	n			
	>47710	SHARLI		Toll W	UNIY	4 ENER	11 170	SIIINC- NO.	1)			
State	31. Dete filed (Month, Day, Year)		ar's Signature	4 1	,							
Registrar	OCT 0 2	ZUUO	enera	D ppa	els							

Barnes, Elizabeth Hannah



Physician	1 Decedent's Name (First Middle Leat)		Cen	tificate	of Dea	1111	2. Deta of De	Reg. No.	00 3255			
/Medical	1. Decedent's Nama (First, Middle, Last)  ANNA E. BOND							Dey	Yeer 2000 530A			
Examiner	4a Facility Name (If not Institution, giva street er		105.00		4b. Cit	y, Town, or Lo		ocation of Death 4c. County of Deeth				
	Fallston General Hosp		Y	W11-1-43	1	elston	1	Harfo				
Funeral Director	5. Sociel Security Number 6. Sax 1 ☐ M 25	7. Aga (In yrs. ) 92	Yrs.	ff Under 1		Inder 24 Hrs. ours Min.	8. Date of Bir (Month, De Jan. 8	, 1908	9. Birthplaca (State or Forei Country) Mary Land			
8 11	Usuel Residence of Decedent  10a. Stete 10b. County	10c. City	y, Town or Loc	cation					10d. Inside City Limi			
25e-t sh notified_n rector												
or 25a-f sho as notified at Director	10e. Street and Number 10f. Zip Code							10g. Citizen of V	Whel Country?			
1 10	246 Kensington Parkwa		210	09			u.s.A.					
Examiner must be notified by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced  12. Was Arm  1 Yes	.S. 13. Was Decedent of Hispanic Origin? (Speciff Yes, specify Cuben, Mexican, Puerto Ri				ecify Yes or No Rican, etc.)	ify Yes or No- lican, etc.)  14. Race - American Indien, Bleck, White, etc.  Specify: White					
	15. Decedent's Education (Specify only highest grade comple	16e. Decedent's Usuel Occupation				ina	16b. Kind of Business/Industry					
Completed	Elementary/Secondary (0-12) Colle	ege (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)				ary					
ő	8th grade  17. Father's Name (First, Middle, Last)	Seams	stress	10.1	Mathada Nam	o /Eirst Middle	(First, Middle, Maiden Sumeme)					
o Be												
F	19e. Informent's Neme/Relationship (Type, Print							ia Bores r Rural Route Number, City or Town, State, Zip Code)				
9	Joan T. Godbee (Daugh		1			Parkwai	y, Abingdon, MD 21009					
	20e. Method of Disposition	20b. P	teca of Dispos	sition (Nema	of		Dele 20c. Location - City or Town, Stete					
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a	Schimuner Funeral Home of Bel Air, II 610 W. MacPhail Road, Bel Air, MD											
ian cat	23a. Pent. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset end Death  Immediate Cause (Finet disease or condition  a. Metastatic Colon Cancer  2 week											
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should be detached for ieted by Physicia	Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert t.							23b. Did tobacco use contribute to the cause of death				
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Certification:	2 Accident Investigetion 3 Suicide 6 Could not ba determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rurel Route Number, City or Town, State)				
completely filled Medical Ce	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.  (Check only one)  Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	29c. Licansa number 29d. Data signed (Month, Day, Year)								d (Month, Day, Year)			
N N		1 Mu mp 253462						9/29/00				
×	Min	a on		1	530	162	*.	91=	29/00			
Completely filled  Medical C	30. Name end address of person who completed	I cause of deeth (Item	23a) (Type, P		2230	462		918	29/00			

DHMH 16 Rsv 6/95

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Pleas	se Type or	Print In F	Black In	delible	e Ink	Assur	re All	l Coples	Are Leal	ble.			
		of Marylan	d / Depa		t of H	lealth ar		lental Hyg	giene () (	0 325	53		
Decedent's Neme (First, Middle,	Last)			Timout	5 0	Douth		2. Dete of Dea	Reg. No. ath	3. Time	of Deeth		
Helen Sunday Baqwell September 29, 2000													
4e Facility Name (If not institution,	4					4b City Tow		septemo					
		Service Control											
Harford Memor  5. Sociel Security Number	ial Hosp:	ital 7. Age (In yrs. I	het hirthday	) If Under	1 Year	Havre	4 Hrs.	8 Date of Birth	Harf	9. Birthplece (Stet	to or Foreign		
	1 M 2½ F		Yrs.	Months Devs			Min.	oct. 25	Year) 910	Country)			
203-09-9582   Usual Residence of Decedent		89						000. 20	, 1310	New Jers	ey		
10e. Stete 10b. County	===	10c. City	y, Town or Lo	ocation				4		10d. Inside	City Limits		
MD Har:											es 2□No		
10e, Street and Number	TOLG		acci ac	10f. Zip	Code				10g. Citizen of V	What Country?			
46 Smith Aven					210				U.S.	Α.			
11. Meritel Status	12. Was Dec	edent Ever in U,: orces?				dispanic Originan, Mexican, I		ecify Yes or No- Rican, etc.)		ce - American Indian, ck, White, etc.			
1 ☐ Never Merried 2 ☐ Married 3 ☐ Mildowed 4 ☐ Divorced	if Yes, Gir Yeer or D	ive		1□Yes 2□No Specify:					Specify	White	White		
15. Decedent's (Specify only highest	grade completed)		(Give	edent's Usue e kind of wor DO NOT us	rk done	during most o	of worki	ing	16b. Kind of Bu	usiness/Industry	iness/Industry		
Elementery/Secondary (0-12)	College (	1-4or 5+)	Bill	ing					Telephone Company				
17. Fether's Neme (First, Middle, La			And the time and	11.19		18. Mother	's Name		Maiden Sumem		· y		
Jacob Sunday						Mar	C	+~anaha					
19e. Informant's Neme/Relationship	n (Tune Print)		19h Mail	ing Address	Street			straugha		State, Zip Code)			
Joan B. Zentr		ahter)						en, Mary		4004			
	ICK (Dau					, ADEL	ruec	-		City or Town, Stete			
20e. Method of Disposition  1  Buriel 2 Cremetion 3 Removal from Stete  4 Donetion 5 Other (Specify)  20b. Place of Disposition (Neme of camefory, cremetory or other place)  Baker Cemetery  10/3/00  Aberdeen													
21. Signeture of Funeral Servica Lie	censee					ess of Fecility							
► husten A	myDe	yest	le	Aberd	leen,	Maryl	land	eral Hom 1 21001	-3399				
23a. Pert1. Enter the disease, or co shock, or heart feilure. List or	emplications that only one cause on a	aused the deetr	n. Do not en	ter the moa	e of ayır	ig, such es ce	erdiec o	or respiretory and	rest,		mete Between nd Death		
immediate Cause (Final disease or condition resulting in death)		CVA											
		Wo	sep	squence off		, (	H	F					
Sequentially list conditions, if any, leeding to immediate		Pue to (or	La Conso	aquence af):	1	+	1 1						
cause. Enter Underlying Ceuse (Diseese or injury that initiated events	c	7000	ele z	uje	pre	telec	N	gual	such	1			
resulting in death) Lest		M	alu	utin	tro	n		0					
	-10-11									Î			
Pert II. Other significant conditions	contributing to d	eath but not resu	ulting in the c	oderlying o	ause giv	on in Part I.	-1			ontribute to the cause 3 ☐ Probably 4	oe of death?		
cur	our	un	al q	10	ue	care	w				/		
24e. Wes en eutopsy performed?									24b. Were autopsy findings aveilable prior to completion of cause				
								10 Y	Yes 2 No	of death?	2□ No		
25. Wes case referred to medical		1				26. Plece	of Deeth	h (Check only o	ne)				
exeminer?	Hospitel: 1 Propatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Spec									ner (Specify)			
27. Manner of Death  1 Natural 5 Pending 2 Accident Investige	28a. Date (Mon	of Injury oth, Day Year)	28b. Time o		28c. Injur Wor		1		how injury occur				
2 Accident Investige 3 Suicide 6 Could no 4 Homicide determin	ot he							28f. Location (Street and Number or Rurel Route Number, City or Town, State)					

Examiner Medical Certification: To Be Completed by Physician/Medical Examiner Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Otrector: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burtar To the Hospital or Attanding Physician: The law

Seh1 00-86-80

Helen Bagwell

**Physician** /Medical

**Physician** /Medical

Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If them 27 is merited other than "natural", or thems 23s or 25s-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier

29c. License number

29d. Date/signed (Month, Day, Year)

30. Name and address of person who completed sause of deeth (Item 23a) (Type, Print)

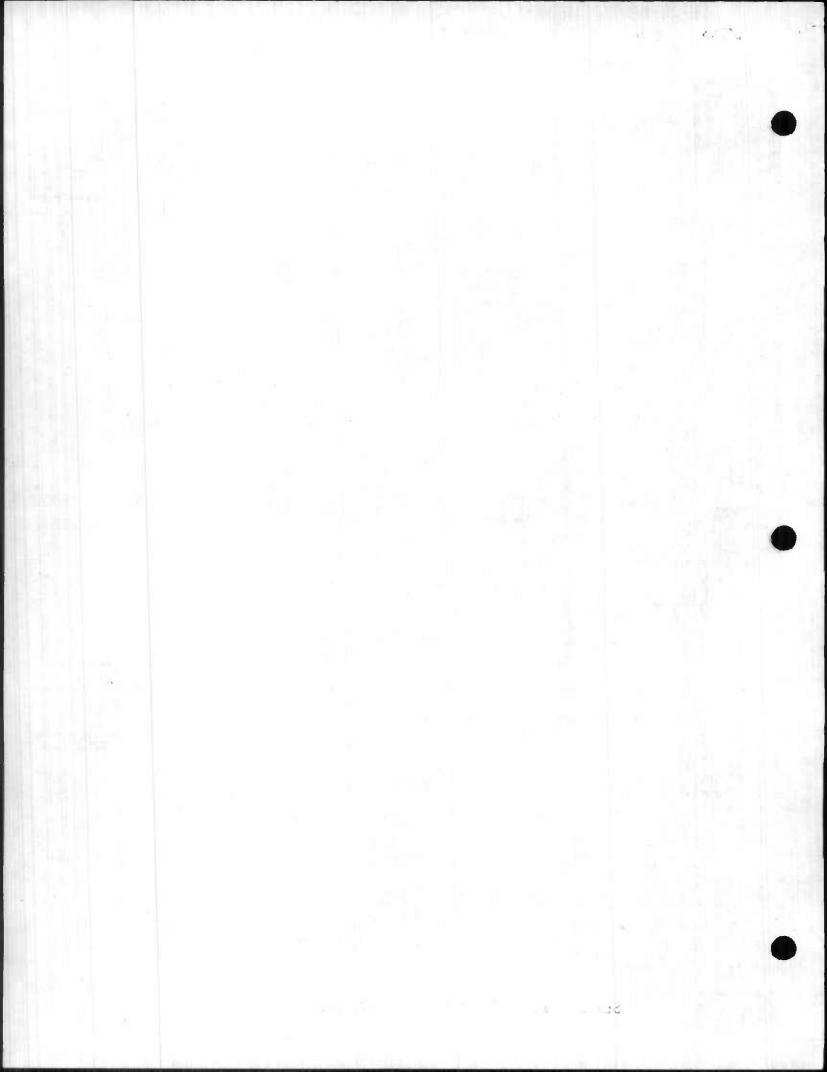
31. Date filed (Month Cay, Year)

32. Segistrer's Signeture

State Registrar



			Amend # 23	b 9-28-0	aryland /			Death H	1H1	Reg. No.	135	554	
	Physici	an	1. Decedenl's Neme (First, Middle,			2. Date of De			3. Time of Death				
4	Physici /Medic		Avis Ede		September 27, 2000 6:0								
زر	Examir	ner	4e Facility Name (If not institution,					lb. City, Town, or Li					
1			3738 Federal Lane 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1					Abing If Under 24 Hrs.		Harford  Right			
L	Funeral Director	П	491-01-4406 Usual Residence of Decedent	1□ M 2[XF	AA			Hours Min.	8. Date of Bird (Month, Da Nov. 1				
	yland		10a. State 10b. County 10c. City, Town or Location								10d.	Inside City Limits	
	Be-f	Director	Maryland Harford Abingdon									1 ☐ Yes 2 ☐ No	
	with th	Pre										?	
	ne 23	Funeral	11. Marital Status	12. Wes Decedent	Ever in U.S.	13. Was [			ecify Yes or No		14. Race - American Indien,		
020 urs after d af, or item	72 hours after death with the Maryland natural, or items 23s or 28s4 show sides Exemple must be notified	by	Armed Forces?  1 Never Merried 2 Merried   Yes 2 No   Yes, Give Year or Detes:				specify Cuba es 2⊠No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Specify	ck, White, etc.		
5-0		peted	15. Decedent's (Specify only highest	16	16a. Decedent's Usual Occupation (Give kind of work done during most of work				16b. Kind of Bu	usiness/Indus	try		
21215-0020		Completed	Elementery/Secondary (0-12)		College (1-4or 5+)			(Give kind of work done during most of working life. DO NOT use retired) OMEMAKET			omo		
	H Hygi		17. Father's Neme (First, Middla, Le	ist)		IIOIIGIIG	KEI	18. Mother's Nem		Own Home			
Maryland	A P P S	To Be	Jesse Edmund	Smith				Flossie	e Dell Ferguson				
lan	and and and and and		19e. Informent's Neme/Reletionshi			All Call Car		and Number or Run	Rural Route Number, City or Town, State, Zip Code)				
	2 5 5 7 F		Judy K. Hughes	/ Daughter				Lane, Ab		-		0	
Baltimore,	20 - 2		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3		cemet	of Disposition ery, cremetory	or other plac		Date	20c. Location -			
Itin			4 Donetion 5 Other (Spe 21 Signature of Funeral Service Lie		Ozark	Memor 22 Nan	ial ne and Addres		-30-00	Joplin,	Misso	uri	
Ba	permit. Departminents any inju		. //// / ^	MI I		Macin	mag Elm	aaral How	e, P.A.	_			
			23a. Pert1. Enfer the disease, or co	omplications that caused	the death. Do	not enter the	mode of dyin	g, such es cardiac	or respiretory e	rest. Ma	ryland	21009 pproximate terval Between	
	Physician		Cnset end Deeth										
	/Medical Examiner		Immediate Cause (Fine) disease or condition resulting in death)  a. / Levul FAILURE										
L		Jer	Due to (or as a consequence of):										
1	eath cartificate be assecuted attending physician and i for use as the bunal-transit	Examine	Sequentially list conditions,	b	Due to (or es	consequence	10):	/   )					
20,	icate be axecuted physician and s the burial-transit		Sequentially list conditions, if any, leading to immediala cause. Enter Underlying Cause (Disease or injury	6							į		
68760,	physicate the the	odlo	O   thet initiated events										
Box (	death cartif e attending od for use as	NZM.		<b>d</b>									
	death e atte	sicia	Pert II. Other significant conditions	contributing to death b	ut not resulting	in the underly	ing cause give	en in Pert I.	23b. Did 1	obacco use co	ntribute to th	e cause of death?	
P.0	res that the de signed by the a I be detached f	Physician/M	PALICINSON		SRASE				10	Yes 25(No	3 Probeb	oly 4 Unknown	
	lres th signer d be d	þ		> //	JE AS C						045 345	and a second second	
Records,	been should	Completed								en eutopsy med?	eveila	eutopsy lindings ble prior to letion of cause	
Re	The law ata has b paga 2 s	dmc							10)	of deeth'		2.1	
Vital		Be C	25. Wes case referred to medical					26. Place of Deet			101	65 20010	
of <	G 60 X	ToE	axaminer? 1 ☐ Yes 2015 No	Hospitel: 1 Inpatio		Outpatient 3[	DOA Oth	er: 4 Nursing Ho	ome 5 Resid	dence 6 □Oth	er (Specify)		
טם	P 25 5		27. Manner of Death  ☐Naturel 5 ☐ Pending	28a. Dete of Inju (Month, Da	y Year) 28b.	Time of Injury	28c. Injun Worl		28d. Describe I	now injury occur	red		
Division	Attending in death.	licat	2 Accident investigat 3 Suicide 6 Could no	be gen Dines of last	uny - At home	M 1 ☐ Yes 2 ☐ No  It home, ferm, street, lectory, office			28f. Location (Street and Number or Rural Route Number,				
≧	after after din b	Certification:	4 ☐ Homicide determine	70	City or Town, Stele)								
	To the Hospital or Attendit within 24 hours after death, To the Funeral Director: A completely filled in by the formal completely filled in the formal completely fi	edical C	29a. Cartifier Check only only Medical Ex	Physician: To the best aminer: On the basis of and manner ste	axamination a	ge, death occu nd/or investiga	rred et the tim ation, in my op	ne, date and place, pinion, death occur	and due to the red et the time,	cause(s) and me date and plece,	enner es state end due to the	id. e cause(s)	
	Within To th	-	26b. Signature and title of certifier	29c. License	number		29d. Dete signed (Month, Dey, Year)						
			1/00	CW ~				053536 9/27/00			0		
	10		PANIEL GO	o completed cause of d	leath (Item 23a)	(Type, Print)	( a	ives in E	Pken	y Be	elcame	21017 MD	
	Sta Registra		31. Date liled (Month, Day, Year) SEP 28	2000 32. Registr	ar's Signature	B. ,	pork	2					

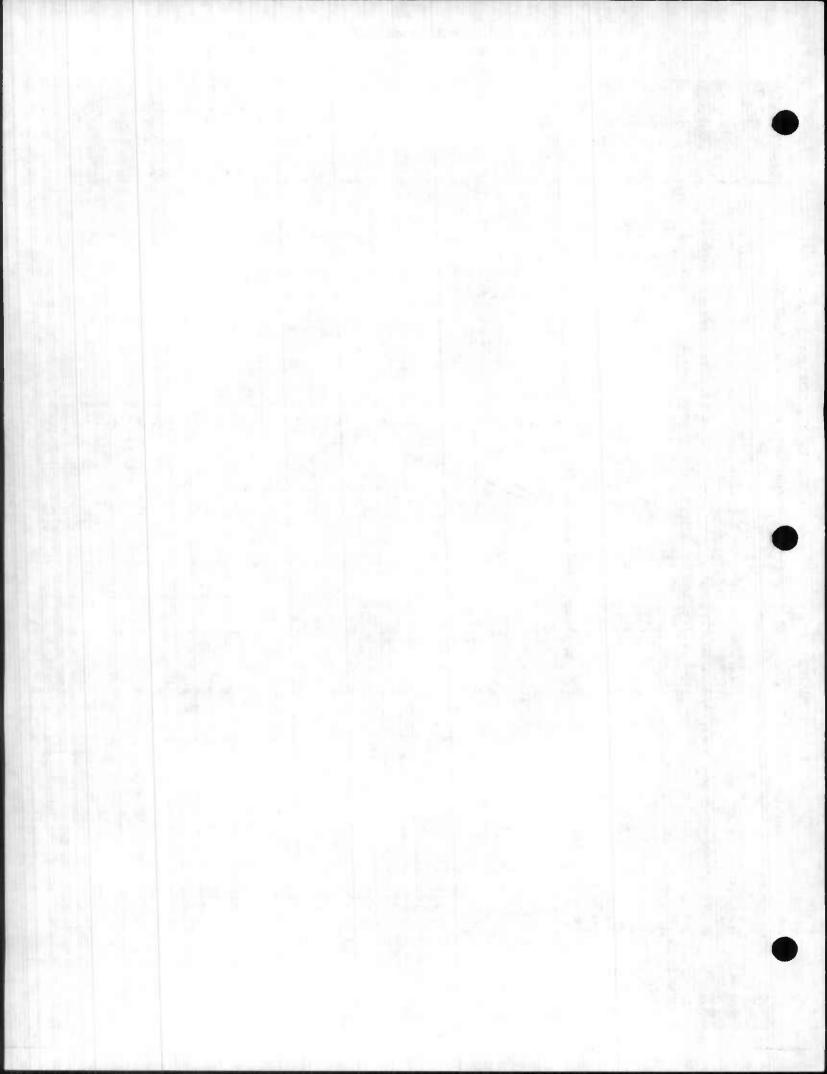


cian	1. Decedent's Nama (First, Mic	Idla, Last)				tificate of		2. Deta of De			Time of Death
al	ANTOINETTE LOU	ISE BO	NGAR	DT				Sept.	24, 2000	O <sup>Year</sup> 5	:45 a.m
	4e Facility Name (If not Institut	ion, give stre	et end nu	m <i>ber</i> )	== IIE		4b. City, Town, or I	ocation of Deat	h 4c. County	of Death	
	Stella Maris H		2	- A 41 · · ·		If Under 1 Yaar	Towson If Under 24 Hrs.	Data of B		imore	(C)
	5. Sociel Security Number 215–30–6638	6. Sex	2 <b>X</b> F	65	s. last birthday) Yrs.	Months Deys		(Month, De Oct. 1	9, 1934	Country) Maryla	(Steta or Foraig and
	Usual Residence of Decedent  10a. State 10b. Coun	tv		10c. 0	City, Town or Lo	cation				10d. li	nside City Limits
	Maryland Harf	ord		R	orest H	411			1 ☐ Yes 2		
	10e. Street and Number	OLU			OTCOC D	10f. Zip Code			10g. Citizen of V	What Country?	100 NF
l	10 Lockhart Ci	rcle,	Apt.	F		21050					
1	11. Meritel Stetus 1 ☐ Never Merried 2 🖫 M	erried	Armed Fo	2 No			Hispanic Origin? (S pan, Mexicen, Puart	pecify Yes or No o Rican, etc.)	Blac	e - Amaricen In ck, Whita, etc.	dian,
	3 Widowed 4 Divorce	ed	If Yes, Gi Yaar or E			1 □ Yes 2 No			Specify	WILLE	
L	(Specify only high		mpleted)		(Give	lent's Usual Occu kind of work done DO NOT use retin	during most of wor	king	16b. Kind of Bu	usiness/industr	
	10th grade	)	Collega (	1-4or 5+)		emaker			Own Ho	ome	
ŀ	17. Fathar's Neme (First, Middle	e, Last)			1112-24		18. Mother's Nan	na (First, Middle	, Maiden Sumem	na)	
	Casimier Novak						Anna Ca	ester			
	19a. Informant's Name/Ralatio			(been			ot end Number or Ru				
	Robert G. Bong	ardt	(nust			sition (Neme of	Circle, A	Dete	20c. Location -		
	1 X Burial 2 ☐ Cremetion		oval from	Steta	cemetary, crar	netory or other pla					
ļ	4 Donetion 5 Other  21. Signature of Funeral Service			S		eart of	Mary Cem	9/2//00	Dundal	k, Mary	Jand
	5//	11	11		S	chimunek	Funeral				
	23a. Pert1. Enter the disease,	or complicati	ions thet	ceused tha da	ath. Do not ant	er the mode of dv	ncPhail Ro	or respiratory a	rrest,		14 roximate
	shock, or haert failure. U	ist only one c	euse on (	eech line.						Inte	rvet Between sat and Death
	Immediata Causa (Final disease or condition		TIII	NG CANO	oed					1	
	rasulting in death)	a	LU		(or es a consec	quence of):					
Sequentially list conditions, if any, taeding to immediata cause. Enter Underlying											
	Sequentially list conditions,	6		Due to	(or es e consec	juance of):					
	if any, taeding to immediata cause. Enter Underlying Cause (Disaasa or Injury	<b>S</b> b									
	if sny, taeding to immediata cause. Enter Underlying	c			(or es e consec						
	if any, faeding to immediata cause. Enter Underlying Cause (Disaasa or Injury that initiated events	c									
	if any, faeding to immediata cause. Enter Underlying Cause (Disaasa or Injury that initiated events	c	uting to d	Dua to	(or as a consaq	uence of):	ivan in Pert t.	23b. Did	tobacco usa co	ntributs to the	causs of death
	if sny, laeding to immediata cause. Enter Undertying Cause (Disaasa or Injury that initiated events resulting in death) Last	c d	uting to d	Dua to	(or as a consaq	uence of):	ivan in Pert t.		tobacco usa co Yes 2□ No		_
	if any, taeding to immediata cause. Enter Undertying Cause (Disaasa or Injury that initiated events resulting in death) Last	ctions contrib	uting to d	Dua to	(or as a consaq	uence of):	ivan in Pert t.	1 🗆	Yes 2 No	3 Probably	y 4 <b>X</b> ) Unkno
	if any, taeding to immediata cause. Enter Undertying Cause (Disaasa or Injury that initiated events resulting in death) Last	c d tions contrib	uting to d	Dua to	(or as a consaq	uence of):	ivan in Pert t.	1 □		3 Probably 24b. Were e	y 4X Unkno
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	if any, laeding to immediate cause. Enter Underlying Cause (Disaasa or Injury that initiated events resulting in death) Last  Pert II. Other significant conditions to the conditions of the con	Del Hoss	pital: 1 □	Dua to eath but not re	(or as a consage soluting in the u	uence of):  ndarlying ceusa g	26. Ptece of Deather: 4 ☐ Nursing H	24a. Wes perf	Yes 2□ No sen autopsy ormed?  Yas 2▼ No one) idence 6▼Oth	3 Probably  24b. Were e everyles of deet  1 Ye	utopsy findings le prior to tion of cause h?
	ary, laeding to immediate cause. Enter Underlying Cause (Disaasa or Injury that initiated events resulting in death) Last  Pert II. Other significant conditions to the condition of the conditio	Del Hosp	Dital: 1 🗆 28e. Dete	Dua to eath but not re	(or as a consaque saulting in the u	uence of):  Indarlying ceusa g	26. Ptece of Deather: 4 ☐ Nursing H	24a. Wes perf	Yes 2 No sen autopsy ormed?  Yas 2 No one)	3 Probably  24b. Were e everyles of deet  1 Ye	utopsy findings le prior to tion of cause h?
	25. Wes cese referred to mediexaminer?  1 Yes 2 No  27. Menner ol Deeth  28. No  29. Menner ol Deeth  29. Accident  20. Accident  20. Cou	Hosp	pital: 1 🗆 28e. Dete (Mor	Dua to eath but not re linpatient 2: oil Injury e oil Injury - At	cor as a consaquesulting in the understanding in th	uence of):  Indarlying ceusa g	26. Place of Deather: 4 □ Nursing Hury at ork? □ Yes 2 □ No	24a. Wesperfine 1 ath (Check only lome 5 Res 28d. Describe 28l. Location	Yes 2 No sen eutopsy ormed?  Yas 2 No one) idence 6 Oth how injury occur	3 Probably 24b. Were e eveileb comple of deett 1 Ye	utopsy findings le prior to tion of cause h? s 2 No
	25. Wes cese referred to medie examiner?  1 Yes 2 No  27. Menner ol Deeth  1 Neturet 5 Penner ol Deeth  1 Neturet 5 Penner ol Deeth  1 Substide 1 Neturet 5 Penner ol Deeth  2 Accident 3 Substide 6 Coul	Hosp ding stigetion d not be	pital: 1 🗆 28e. Dete (Mor	Due to eath but not re linpatient 2 of Injury th, Dey Year)	cor as a consaquesulting in the understanding in th	uence of):  Indarlying ceusa g  Int 3 DOA O  Int 28c. Inj  W  M 15	26. Place of Deather: 4 □ Nursing Hury at ork? □ Yes 2 □ No	24a. Wesperfine 1 ath (Check only lome 5 Res 28d. Describe 28l. Location	Yes 2 No sen eutopsy ormed?  Yas 2 No one) idence 6 Oth how injury occur	3 Probably 24b. Were e eveileb comple of deett 1 Ye	utopsy findings le prior to tion of cause h? s 2 No
	ause. Enter Undertying Cause (Disaasa or Injury that initiated events resulting in death) Last  Pert II. Other significant conditions are summer?  1 Yes 2 No  27. Menner ol Deeth 1 Neturet 5 Peneral Neturet 1 Neturet 1 Neturet 1 Neturet 2 Accident 3 Sulcide 6 Couldet 4 Homicida  29a. Certifier (Check only 2 Medic	Hosp ding stigetion d not be mined ding physicial	pital: 1 🗆 28e. Dete (Mor build	Inpatient 2 of Injury th, Dey Year) e of Injury - At	Cor as a consequence of the unit of the un	uence of):  Indarlying ceusa g  Int 3 DOA O  Int 28c. Inj  W  M 1  Interest, lactory, office	26. Place of Deather: 4 □ Nursing Hury at ork? □ Yes 2 □ No	24a. Wesperfine 1 ath (Check only tome 5 Res 28d. Describe 28l. Location City or To	Yes 2 No sen eutopsy primed?  Yas 2 No one) idence 6 Oth how injury occur (Street and Numburn, State)	3 Probably 24b. Were e eveileb comple of deett 1 Ye  er (Specify) I red  per or Rural Ro	utopsy findings le prior to tion of cause h? s 2 No  HOSPICE
	25. Wes cese referred to medicate cause. Enter Underlying Cause (Disaasa or Injury that initiated events resulting in death) Last  Pert II. Other significant conditions are successful to the conditions of the conditions are successful to the conditions of the conditions are successful to the conditions of the conditi	ding ding stigetion d not be mined fring Physicial Examiner:	pital: 1 🗆 28e. Dete (Mor build	Dua to  Dua to  eath but not re  linpatient 2:  ol Injury  th, Dey Year)  e ol trijury - At  ing, atc. (Spec	Cor as a consequence of the unit of the un	ndarlying ceusa g	26. Place of Deether: 4 Nursing Fury at ork? Yes 2 No	24a. Wesperfine 1 ath (Check only tome 5 Res 28d. Describe 28l. Location City or To	Yes 2 No sen eutopsy primed?  Yas 2 No one) idence 6 Oth how injury occur (Street and Numburn, State)	3 Probably 24b. Were e eveileb comple of deet 1 Ye  er (Specify) I red  per or Rural Ro  anner as stated and due to the	utopsy findings le prior to tion of cause n? s 2 No  HOSPICE
	ary, laeding to immediate cause. Enter Undertying Cause (Disaasa or Injury that initiated events resulting in death) Last  Pert II. Other significant conditions are summer?  1 Yes 2 No  27. Menner ol Deeth 1 Neturet 5 Peneral Neturet 1 Neturet 1 Neturet 1 Neturet 2 Accident 3 Sulcide 6 Could dete	ding ding stigetion d not be mined fring Physicial Examiner:	pital: 1 🗆 28e. Dete (Mor build	Inpatient 2 of Injury th, Dey Year) e of Injury - At	Cor as a consequence of the unit of the un	uence of):  Indarlying ceusa g  Indarlying ceusa g	26. Place of Deather: 4 Nursing Fury at ork? Yes 2 No	24a. Wesperfine 1 ath (Check only tome 5 Res 28d. Describe 28l. Location City or To	Yes 2 No sen eutopsy pormed?  Yas 2 No one) idence 6 Oth how injury occur (Street and Numbin, State) ceusa(s) and madata end ptece, 29d. Dete signe	3 Probably 24b. Were e eveileb comple of deet 1 Ye  er (Specify) I red  per or Rural Ro  anner as stated and due to the	utopsy findings le prior to tion of cause n? s 2 No  HOSPICE

DHMH 16 Rev 6/95

SEPTEMBER 24, 2000 5:45 a.m.

ANTOINETTE BONGARDT



DONALD	REESE	BAKE
ASP		

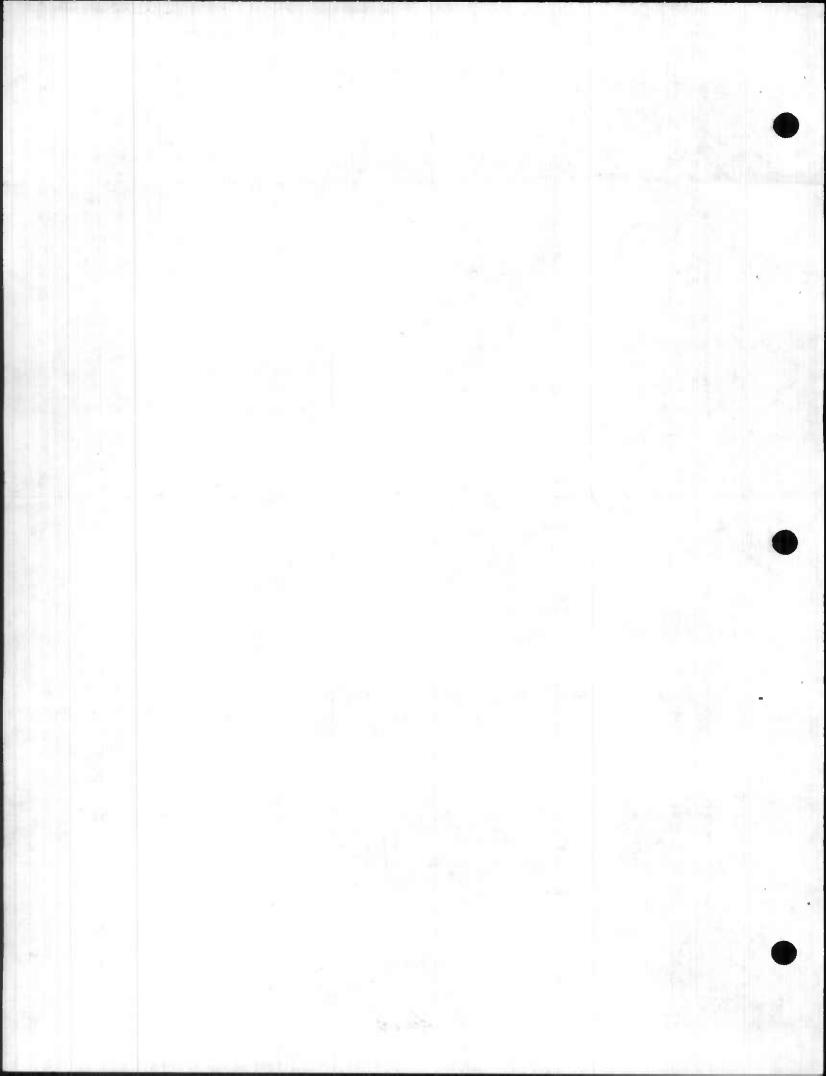
State of Maryland / Department of Health and Mental Hygiene 00 32556

ASP			C	ertificate	e of	Death			Reg. No.		tion 1	
	1. Decedent's Name (First, Middle, Las	et)						2. Data of De	ath		3. Ti	ma of Death
Physician	DONALD REESE	BAKER						Month Augus	Day 31	2000	7.	20 A.M.
/Medical	4a Facility Nama (If not institution, give				1	4b. City. To	wn. or Lo	ocation of Deat		unty of Death		20 A.M.
Examiner	32970 Roy West Ro					Delm				comico		
	-		Marrian da at bilath ala	u) If Undar	1 Vaar	If Undar		0 Date of Sir				Man F'
eral	5. Social Security Number 6. So	G., . C.	In yrs. last birthda Yrs.	Months	Days	Hours	Min.	8. Data of Bir (Month, Da	y, Year)	9. Birth		Itate or Foreign
or	222-22-1339	x 6	2 Yrs.					APR 30	, 1938	3 DEL	AWAR	E
	Usual Rasidence of Decedent  10a. Slata  10b, County	- 1	Oc. City, Town or	Location							10d Inc	Ide City Limits
			oc. City, Town of	Location								Yas 2X No
9	MARYLAND WICOMIC	00	DELMA	R								1142 501140
Directo	10e. Street and Number			10f. Zip	Coda				10g. Citizar	of What Cou	untry?	
air	32970 ROY WEST RO	DAD			2187	75				U.S.A.		
184	11. Marital Status	12. Was Decedent Ev	ar in U,S. 13	. Was Deced	lent of H	lispanic Ori	igin? (Sp	ecify Yas or No	- 14.	Race - Amar		an,
Funeral	1 Nevar Married 2 Married	Armed Forces? 1 ☑ Yas 2 ☐ No						Rican, atc.)		Black, Whita	, atc.	
à	3 ☐ Widowed 4 ☐ Divorced	If Yas, Giva Yaar or Datas:	1956-59	1 □ Yes 2	No	Specify:			Sp	ecity: W	HITE	
	15. Decedent's Ed			edant's Usua	I Occup	ation			16b. Kind	of Business/I	ndustry	Gard Tolland
Completed	(Specify only highest grad	de completed)	(Gi	e kind of wor	k done	durina mos	t of work	ing	}			
Ë	Elementary/Secondary (0-12)	College (1-4or 5+)	C	ARPENT	ER				COL	STRUCT	I'T ON	
Š	17. Fathar's Nama (First, Middla, Last)					18 Moths	ar'e Name	a (First, Middla			LIOIT	
Be		ZED							, maidan 5d	rrama,		
0	REESE MARVIL BAK	CER				VEI	KA .	JOSEPH				
	19a. Informant's Name/Ralationship (7		19b. Ma	iling Addrass	(Street	and Numb	er or Run	al Route Numb	er, City or T	own, State, Z	ip Code)	
	CINDY L. REID / I	DAUGHTER	RT.	1 BO	X 20	)9, L	TTLE	E LANE,	DELMA	AR, DE	1994	40
	20a. Mathod of Disposition		20b. Place of Dis	position (Name	na of	ca)		Data	20c. Loca	ion - City or 1	Town, Sia	ata
	1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Specify		CAPITOL				7 1 0	12/00	DOME	en Dei		D E
	21. Signature of Funaral Sarvice Licens		CAFIIOL	22. Nama and				9/2/00	DOVE	ER, DEI	JAWAI	KE
	21. Signature of Furiaral Salvice Cicent	, 1 L		WATSON	FUN	VERAL	HOME	E, INC.				
	Techand T.	Watso						MILLS	BORO.	DELAWA	ARE	19966
	23a. Part1. Entar tha disaase, or comp shock, or heart failure. List only	olications that caused the	na daath. Do not a	intar tha mode	a of dyir	ng, such as	cardiac	or raspiratory a	rrast,		Appro	ximata al Batween
n												and Death
	Immediata Causa (Final disease or condition	COMPRESSI	ONAL ACDI	UVTA A	ccoc	TATET		PII ACIIMI	e emu	MOT		
VC.	resulting in death)	a. COMPRESSI	ue to (or as a cons		3300	TATEL	MII					
ē			ao 10 (01 ao a con	oquanoa orj.				TNIC	OXICAT	LUN		
Examiner		b								1		
xa	Sequentially list conditions, if any, leading to immediate	U	ua to (or as a cons	equance on:						1		
alE	Sequentially list conditions, if any, leading to immediata cause. Entar Undarlying Cause (Disease or injury that initiated events	c										
edical	rasulting in death) Last	Du	a to (or as a cons	equance of):								
₹		d										
an an	VOID THE STATE											
Physician	Part II. Other significant conditions co	ontributing to death but	not rasulting in the	underlying c	ausa giv	an in Part	l.	23b. Did	tobacco us	e contribute	to the cr	nuse of death?
hy								10	Yes 2	No 3□Pr	obably	40 Unknown
by F												
B								24a. Was	an autopsy			opsy findings
ete								pend	omad?		availabla complation of death?	on of causa
Completed												
								178	¥es 2□1	No 1	1 Pes	2 No
Be	25. Was casa refarred to medical axaminar?	11- 2-7					a of Deat	h (Check only	one)			
9	1X Yas 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpat	ient 3 DC	Oth	ar: 4 N	ursing Ho	oma 5 🗆 Rasi	idance 6 [	Othar (Spec	oify) SC	ENE
	27. Manner of Death	28a. Data of Injury (Month, Day )	(ear) 28b. Tima	of 2	8c. Injui Wo	ry at		28d. Dascribe	how injury o	ccurred		
atic	1 Natural 5 Pending 2 Accident invastigation		,	М		Yas 2	No					
Certification:	3 ☐ Suicida 6 ☐ Could not be	288. Place of Injury	- At homa, farm,	streat, factory	, office			28f. Location (	Street and I	Vumber or Ru	ral Route	e Number,
ert	289. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)											
										etated		
lica	29a. Cartifier  (Check only one)  1 Certifying Physician: To the basis of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner at the time, data and place, and due and manner stated.										ause(s)	
Me										(aar)		
~	29b. Signatura and titla of certifier	29c. Licansa number 29d. Data signed (Month, Day, Year)										
O.C.M.E SEPTEMBER 01,2							1,20	UU				
	30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)									1 9		
	1 lanne Chil	teno			enn	Stre	et.	Baltimo	re, M	arylan	d 21	201
State	31. Date filed (Month, Day, Year)	32. Registrar	s Signatura							-		
1217	, , , , , , , , ,	a logional	70									

State

Registrar

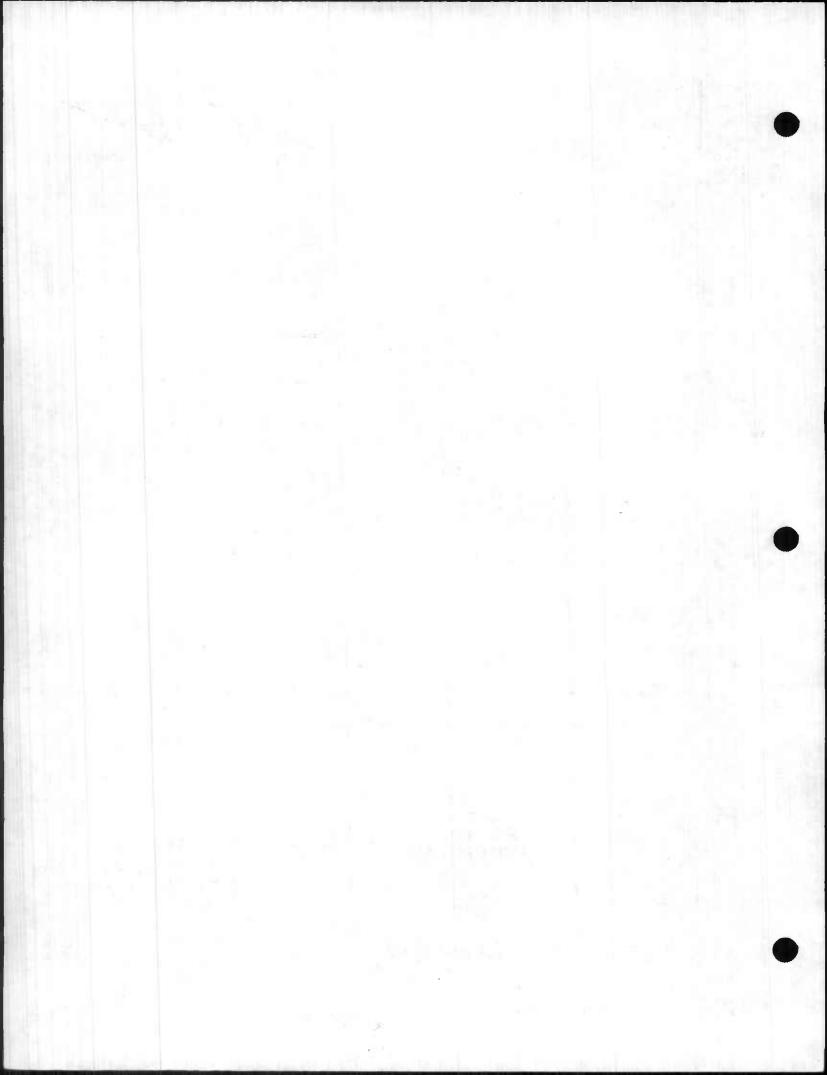
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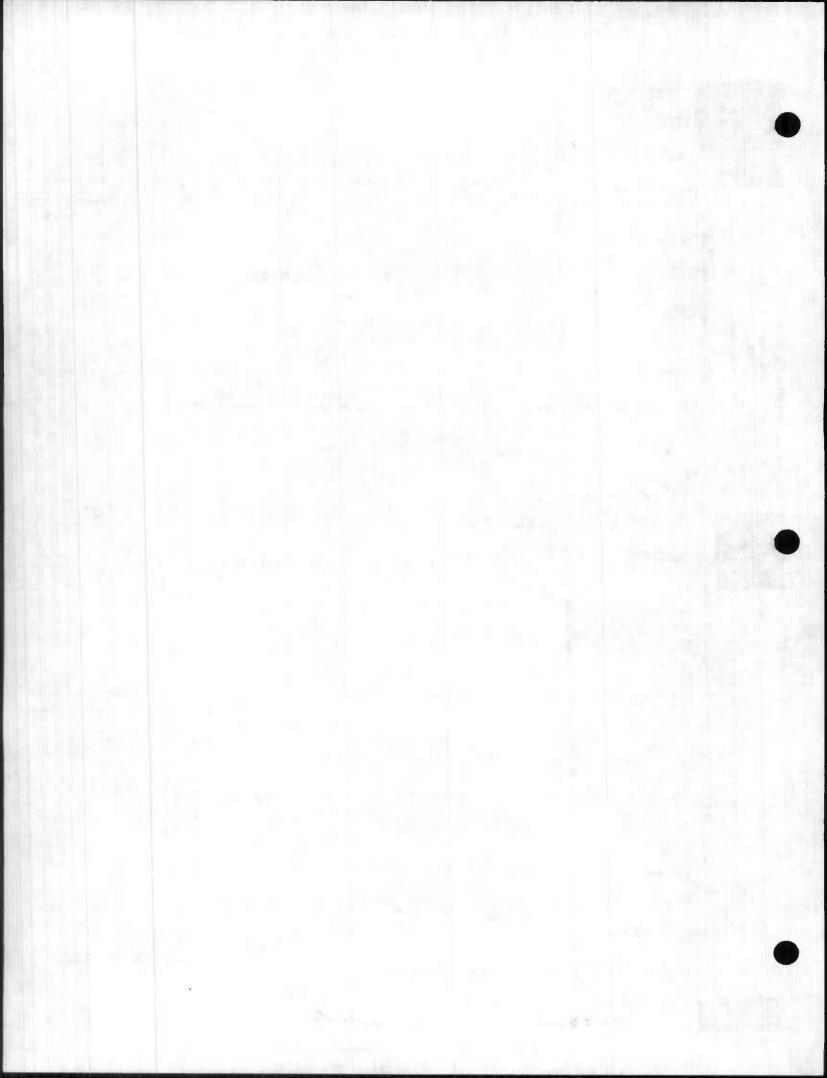
CERMIT R	LCH/	ARD BROADWATER		Cei	rtificate of	Death	R	leg. No.	0 0	12001
		1. Decedent's Neme (First, Middle, La	st)				2. Dete of Dear	th Dey	Yeer	3. Time of Death
Physic /Medi		KERMIT RICHARD B	ROADWATER				SEPT.	12, 200		0805 AM
Exami	_	4e Facility Name (If not institution, given 292 NORTH PARK				4b. City, Town, or I		4c. County GARRI		
Funeral Director	_	210-22-4100	ex 7. Age (In y. X) M 2□ F 74	rs. lest birthdey) Yrs.	If Under 1 Yee Months Deys		8. Dete of Birth (Month, Dey FEB 5,		9. Birthple Countr MARYI	
f show	or	Usuel Residence of Decedent  10a. Stete 10b. County  MD		City, Town or Lo				•	100	d. tnside City Limits 1 ☑ Yes 2 ☐ No
with the Maryland ta or 28e-f show the notified at	i Director	10e. Street and Number 1719 HOLLINS STR	EET		10f. Zip Code	21223	1	10g. Citizen of Whet Country? USA		
hours after death turnf, or flams 2: at Examiner mus	by Funeral	11. Maritel Stetus  1 Never Merried 2 Married  3 Widowed 4 Noivorced	12. Wes Decedent Ever in Armed Forces? 1-\$\text{N} Yes 2 □ No If Yes, Give Yeer or Detes: \text{WW}		Wes Decedent of If Yes, specify Cui	Hispenic Origin? (S ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	No- 14. Rece - American Indien, Black, White, etc.  Specify: WHITE		
d 2 should be filed within 72 hours at the and Mental Hygene. 7 is marked other than "natural", or traumatic event, the Medical Exam	petel	15. Decadent's E (Specify only highest gr	ducation de completed)	(Give	dent's Usuel Occu kind of work done DO NOT use retin	during most of wor	king	16b. Kind of Bu	usiness/Indu	ıstry
od with ygiene. er than	Completed	Elementery/Secondery (0-12) 11 th	College (1-4or 5+)		IFT OPER	RATOR		MANUFAC		1G
femal H femal H feed off	o Be	17. Fether's Neme (First, Middle, Last NEVIN ULYSSES BR					ne (First, Middle, I CSTELLE C			
nd 2 shoulth and N 27 is mar r traumat	-	19e. tntorment's Neme/Reletionship (RONALD L. BROADW				et and Number or Au				
semit. Pages 1 a Separtment of Hea reportant: If Item any Injury or other Rice.		20e. Method of Disposition  1 2 Buriel 2 Cremetion 3 C 4 Donetion 5 Other (Specia	Removel from Stete	cemetery, cres	osition (Name of metory or other pl LLE CEM.	SEPT 16		20c. Location - GRANTSV		
permit. Departri importa any inja		21. Signeture of Fundral Service Lice	bernaen	NE		ress of Fecility NERAL HOMI R ST. GRAN			275 1536	
Physician /Medical Examiner	her	23a. Pert1. Enter the disease, or com- shock, or heart at unit. List only transdiate Ceuse (Final disease or condition resulting in deeth)	e. Contac		ishot u	ound o				Approximete Intervel Between Onset end Deeth
cate be executed physician and sthe burial-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or es e consec	quenca of):					
ding Jse as	n/Medical	Cause (Diseese or injury thet initieted events resulting in death) Last	Due to	(or es e consec	quence of):					
the death by the atte	Physician/	Pert II. Other significant conditions of	ontributing to death but not	resulting in the u	ınderlying cause ç	given in Pert I.		obacco uss co		the cause of death?
s lew requires the has been signed by 2 should be d	Completed by						24a. Wes e pertor LIM	med? Hed	evei com of d	re eutopsy findings ilable prior to npletion of cause leeth?
certificate he		25. Wes case referred to medical				00 Di (D-		es 2 No	Up	Yes 2 No
Physician: this certific ral director,	o Be	examiner?  1x Yes 2 No	Hospitel: 1 ☐ Inpatient 2	□ ER/Outpatie	nt 3 DOA	Mhorr	ath <i>(Check only</i> or lome 5 ☐ Resid		er (Specify	AT SCENE
iling Ph After th funeral	Certification: T	27. Menner of Deeth  1 Neturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Year) 9-11-2000	28b. Time o	28c. Inj W		28d. Describe h	ow injury occur Shet	self	
P # 5 =		3₺ Suicide 6 Could not be determined	building, etc. (Spe	city			Garrett C	aunty 1	Many	land land
Ne Hospital n 24 hours Ne Funeral pletely filled	edical		yelclan: To the best of my linner: On the basis of exem and menner steted.							
To the within 2 To the comple	M	29b. Signeture end little of certifier  Atysy	Mac	ly, M.	ρ 0.	c.M.E	1	SEPT		Dey, Year) 2000
4	N/A/R	30. Name end eddress of person who	completed cause of deeth (I	111 Pen		, Baltimo	ore, Mary	land 21	1201	
St	ate	CED 1	2000 1	grioturo	h /					



State of Maryland / Department of Health and Mental Hygiene

00 32558

									Death			Reg. No.		
	1. Decedent's	Name (First, Mic	iddle, Last)	)		9121					2. Dete of De Month	eath Day	Year	3. Time of Death
Physician /Medical	Jo	seph	Fo	rd	Bowes	5						er 21,		4:00 a.ı
aminer	4a Facility Na	me (If not institut	tion, give s	street end nu	n <i>ber)</i>			4	4b. City, To	wn, or Lo	cation of Deat	h 4c. Cou	nty of Deeth	1
	17	785 Clar	rke R	load	Care				Tall				Mary	s
al	5. Social Secu	irity Number	6. Sex	M 2 F	7. Age (In yrs.		) If Und Months	er 1 Yaar Deys	If Under Hours	24 Hrs. Min,	8. Date of Bir (Month, Da	th ly, Year)	9. Birth	plece (Stete or Foreign intry)
tor		1-4028			86	Yrs.		<u></u>			Oct. 2	20,1913	Wash	ington, D.C.
	10a. Stata	nce of Decedent 10b. Cour			10c. Ci	ty, Town or L	ocation							10d. Inside City Limits
ò														1 ☐ Yas 2 ■ No
Directo	Maryla		. Mar	y's	Vā	alley 1		ip Code				10g. Citizen	ot What Cou	intry?
	117	00 m 11	m· 1						0.0					
Funeral	11, Merital Ste	80 Tall		12. Wes Dece	dent Ever in L	J.S. 13.	. Was Dec	2069 edent of H	ispanic Ori	pin? (Spe	cify Yes or No	United	State Race - Amer	
F		Married 2 M	larried	Armed Fo	2 No		If Yes, sp	ecify Cuba	an, Mexican	, Puerto I	Rican, etc.)		Black, Whita	, atc.
à	3 Widow	wed 4 Divorc	bed	If Yes, Giv Yaer or D			1 ☐ Yas	2 No	Specify:			Spe	city: W	hite
bet		15. Deced				16a. Dece	edent's Us	uel Occup	etion			16b. Kind o	Business/li	ndustry
Completed		(Specify only high Secondary (0-12)	-	College (1	-4or 5+)	life.	DO NOT	use retired	during mos	or workii	ig	Self	employ	ved-
P P	12	000000000000000000000000000000000000000		00090 (1	401 017	Book	stor	e owi	ner					k store
Bec	17. Fathar's N	ema (First, Middi	lla, Last)						18. Mothe	r's Name	(First, Middle	, Maidan Sun		
10	Joh	n Ford E	Bowes		11.00				Anna	Mae	Matte	rn		
		nt's Neme/Reletio	onship (Ty)	pe, Print)		19b. Meil	ling Addre	ss (Street	end Numbe	or or Rure	Route Numb	er, City or To	wn, Stete, Zi	ip Code)
	Joh	n F. Bow	wes,		Son	P.0	. Box	126	, Com	oton,	Mary1	and 20	627	
	20a. Mathod o	77				Place of Disp cemetery, cre	position (Ne	ame of other pled	ce)		Dete	20c. Locatio	on - City or T	Town, Stata
		tion 5 Other		emovel from		St. Fra	ancis	Xav	ier	19_	25-00	Leonar	dtown	, Maryland
	21. Signaturi	of Euneral Sards	ce Marine	99 6/	1				ss of Facilit	v				
8	19	911111111	24	11/										ome, P.A.
	Pier - Comment	197 K. J. W. W.				0.50			-			_		
	Edwa 23a Perti F	rd N. Br	or compli	ield,	Jr. MOC	0052 2	22955	Hol:	Lywood	Roa	d, Leo	nardto	wn, M	
	23a. Pert1. E shock, o	nter the diseese, or heert teilure. L	or complications on the complete of the comple	ield, cetions thet c ne cause on a	Jr. MOC eused the dee ech line.	th. Do not en	22955 nter tha mo	Ho1: ode of dyin	Lywood ig, such es	Roacardiac o	r respiretory a	nardto arrest,	wn, M	Approximate Interval Between Onset and Death
	23a. Pert1. E shock, o	nter the diseese, or heert teilure. L	or compli- ist only on	cetions thet c ne ceuse on e	eused the dee ech line.	th. Do not er	nter tha mo	ode of dyin	ig, such es	cardiac o	r respiretory a	nrrest,	wn, M	Approximete Intervel Between
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r	23a. Pert1. E shock, o immediate Co disease or co	nter the diseese, or heert teilure. L euse (Finel andition	or compli- ist only on	cetions thet c ne ceuse on e	eused the dee ech line.	th. Do not er	nter tha mo	ode of dyin	ig, such es	cardiac o	r respiretory a	nrrest,	wn, MI	Approximete Intervel Between
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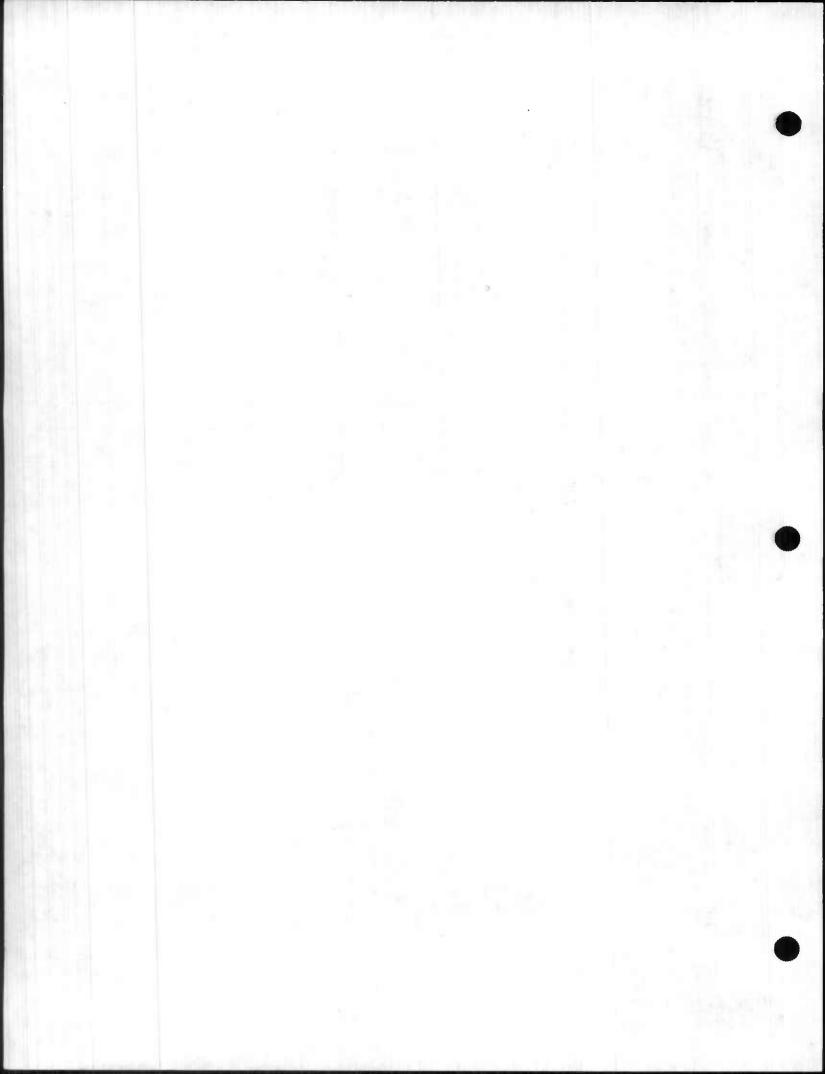


State of Maryland / Department of Health and Mental Hygiene

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					Certifica	te of	Death		F	leg. No.	0 (	66626
		1. Decedent's Nama (First, Middle, La	st)			Ne			2. Dete of Dea Month	th Day	Year	3. Time of Death
Physicia /Medic	_	Christopher	Lee	Bell					SEPTEME	BER 17,	2000	1630 PM
Examine	_	4a Facility Nama (If not institution, giv PT . LOOKOUT ST					4b. City, To		cation of Death	4c. County ST . 1	of Death	5
Funeral Director		546-41-0523	ex 7. Age	(In yrs. last bin	Month	er 1 Yaa s Days		24 Hrs. Min.	8. Dete of Birth (Month, Day July 6	, Year) , 1975	9. Birthpli Count Cali	aca (State or Foraign ry) fornia
and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Location						10	d. Inside City Limits
he Merylar 28a-f ehow	Director	Maryland St. Mar	y's	Cali	fornia					10- 00	15 - 1 0	1 ☐ Yes 2 ■ No
th with t		10e. Street and Number 22545 Joan Drive				206				United	State	es
020 ors a	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forcas? 1  Yes 2 N If Yes, Give Yaar or Dates:				Hispanic Ori ban, Maxicar Specify:		cify Yes or No- Rican, etc.)	14. Rac Bla Specif	ca - America ck, White, e	HC.
5-0 72 ho	Completed	15. Decedent's Ed (Specify only highest gra		16a.	Decedent's Us	ual Occu	ipation e durina mos	at of working	ng	16b. Kind of B	usiness/Ind	ustry
within within than	mple	Elementary/Secondary (0-12)	College (1-4or 5-		(Giva kind of v lifa. DO NOT		ed)					
filed w Hygies ther the		12 17. Father's Name (First, Middle, Last,	1	Fo	od Mana	ager	18 Moth	or's Name	/First Middle		n Foo	d
Maryland 212: d 2 should be filed within d and Mental Hygiene. 7 is marked other than traumatic avent, the M	To Be	Unknown		18. Mother's Nar  Jane Le  19b. Mailing Address (Streat and Number or Re					ise Be	11		
Pages 1 annent of Heal		19e. Informant's Name/Ralationship (  Jane L. Bell McHu  20a. Mathod of Disposition  1 □ Burial 2 ■ Cremation 3 □  4 □ Donation 5 □ Othar (Specification of the Company of	gh Mother	20b. Plece of cameter		ame of	Lookou aca)	t Roa	Data -21-00	Inigoe 20c. Location	S. Ma	rvland
Baltime permit. Pag Department Important: It any Injury o		21. Signatus et uneral Service Con Edward N. Brin	stigld, Jr	.MOO052	1				al Home Road, L		own.	20650 Maryland
		23a. Part1. Entar the disaasa, or com shock, or haart lailura. List only										Approximata Interval Between
Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)	a. D.	OU N	my				100			Onset and Deeth
68760, rificate be axecuted to physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury	b	Dua to (or as a	consequenca o	f):						1000
Box 68760, death certificate be axecuted e attending physician and of for use as the bunal-transit	n/Medical	that initiated events resulting in death) Last	d	Oua to (or as a c	consequence o	):						
death cer death cer se attendir	icia	Part II. Other significant conditions of	contributing to death bu	t not resulting la	the underlying	cause c	iven in Pert	1.	23b. Dld t	obacco use o	entribute to	the cause of death?
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	Completed by									an autopsy rmed?	eve	ere autopsy findings eilable prior to expletion of cause death?
The law	E O								121	es 2□No	10	Yes 2 No
Vital I	Be	25. Was case referred to medical examiner?						e of Death	(Check only o	ne)		
	9	1)X Yes 2□ No		nt 2 ER/Ou		DON			ne 5 Resid			AT SCENE
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Division  or Attending s after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be detarmined	28e. Place of Inju	ry - At homa, fa (Specify)	rm, streat, lact	ory, office	a .	4	28f. Location (S City or Tow	Street and Num vn, Stata)	ber or Rura	Route Number, M.
	edical		ysician: To the best of niner: On the besis of and manner sta	exeminetion an								
To the comple	Me	29b. Signature and title of certifier	tanen	M.	D. 1	9c. Lice	ocmE			29d. Date sign SEPTEM		Day, Year) 8, 2000
(e)		30. Name and address of person who	completed cause of de			Stı	reet,	Balti	imore, 1	Marylan	d 212	01
Stat Registra	_	31. Dete filed (Month, Day, Year)	32. Registra	r's Signatura	. Sp	aks						

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 15 **Physician** 2000 7:55AM James Benjamin Beavan, Sr. /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country)
September 27, 1923 Maryland 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 110 M 2□ F 212-24-4358 76 Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland St. Mary's Chaptico or hams 23s or 28s-f uniner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Herrie 23s or 24790 Hurry Road 20621 U.S.A. Funeral permit. Pages 1 and 2 should be filled within 72 hours after dea Department of Health and Mental Hygiens, important if flam 27 is marked other than any injury or other traumant. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-II Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 (X Yas 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farm 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be Bernard Stanton Beavan, Sr. Lillian Catherine Mattingly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Agnes Marie Beavan (Spouse) 24790 Hurry Road, Chaptico, Maryland 20621 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method ol Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) Queen of Peace Cemetery 9/19/00 Helen, Maryland dure of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Teonardtown, Maryland 20650.

Provided the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately one cause on each line. Approximate Interval Batween Onset and Death **Physician** /Medical Immediate Cause (Final y Lucy Tic Leukemin disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or injury thal initiated events resulting in death) Last Due to (or as a consequence of): Bud physician the burial of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): been signed by the attending pahould be detached for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion ol cause of death? Be Completed 24a. Was an autopsy performed? has pega 2 certificata or Attending Physician: funeral director, 25. Was casa raterred to medical 26. Place of Death (Check only one) 20 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day Year)

28b. Time of Injury 28c. Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes After this 27. Manner of Death 1 Natural 2 Accident 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending Investigation To the Hospital or Attendin within 24 hours efter death. To the Funeral Director: Af 1 TYes 2 □ No the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 3 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Data signed (Month, Day, Year)

pr10

Registrar

BENJAMIN BEAVAN SR.

JAMES

31. Date liled (Month, Day, Year) SEP 1.5 2000

WILLIAM D. BOYD II M.D.

29b. Signature and this of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

28

LEONARDTOWN, MD. 20650

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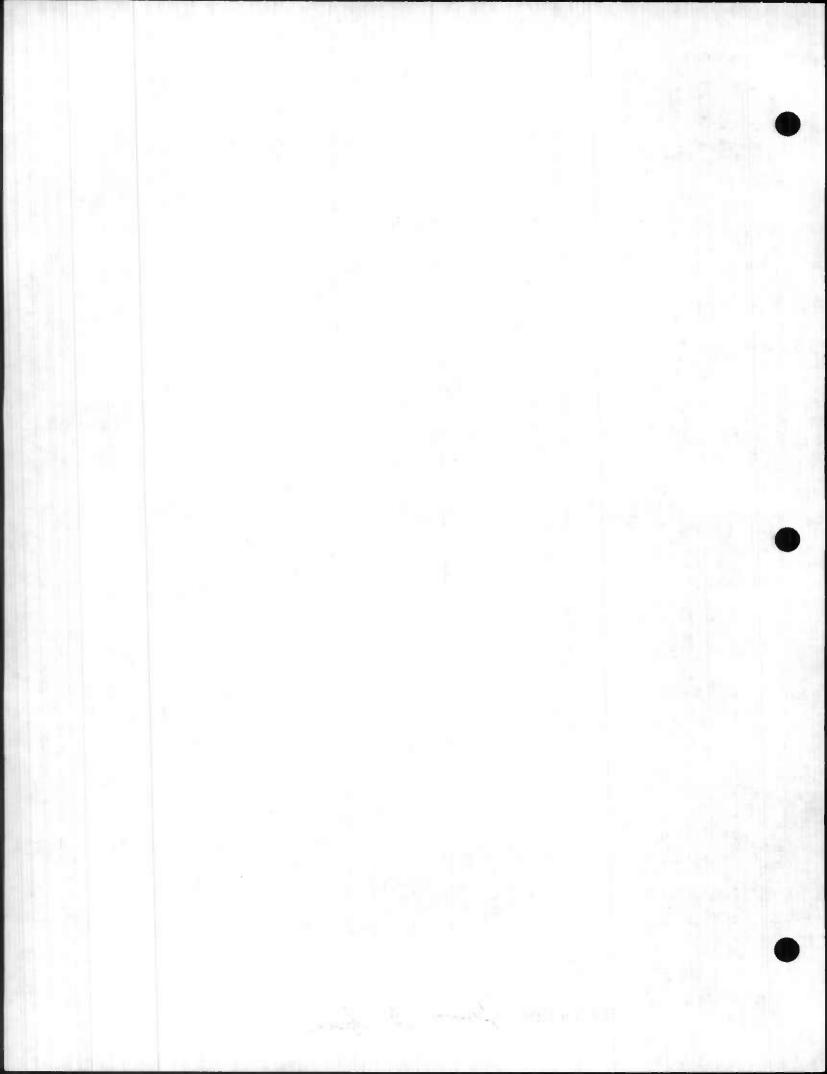
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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al or	5. Social Security Num 219-04-910	nbar 6.	Sax 1 M 2 F	7. Aga (In y	rs. last birth		nder 1 Yaar ths Days	If Under	24 Hrs. Min.	8. Deta of Bir (Month, Da	th ly, Year)	9. Birthp	laca (Stata or Foreign try)
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Director	10e. Street and Number		mary 5		MECHA		. Zip Coda		_		10g. Citizen of	What Cour	itry?
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89				D.									
5	Marvin		ederick	В.	lair			Yvo			Elizabet		Hensley
	19a. informant's Name										er, City or Town		
	Yvonne E.		(Mother)					ew Ro	ad,				yland 2065
	20a. Mathod of Dispos		□Ramoval from		cematary	Disposition r, cramatory	or other pla	100)		Data	20c. Location	- City or To	own, Stata
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Important: any injury once	21. Signature of Funa	ral Service Lic	ensee /			22. Nam	a and Addr	ass of Facili					
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State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #23 PART I, 28A-F PER CERTIFICATE & Death -00 WR. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month HUGUST Yest **Physician** WISE PARKER BULL AGNES 2000 0610 /Medical 4b. City, Town, pr Location of Death 4a Facility Name (If not institution, give street end 4c. County of Death **Examiner** Baltimore Baltimore Hospitalot If Undar 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 7. Aga (In yrs. last birthdey) 5. Social Security Number 9. Birthplace (State or Foreign **Euperal** Days 1 M 2 F VIRGINIA Yrs 231-28-2580 Director AUG. 5, 1928 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r 28a-f show 1 M Yes 2 □ No OAK HALL Funeral Director **ACCOMACK** VIRGINIA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code man 23a or 2 USA 23416 8066 LANKFORD HWY. 12. Was Decedent Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yas 2 ☐ No If Yes, Give X Yaar or Dates: 1 Never Married 2 Married Maryland 21215-0020 6 1 Yes 2 No Specify: WHITE Specify: þ 3 Widowed 4 □ Divorced al Hygiena.
d other than "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) ACCOUNTING/FINANCIAL **BOOKKEEPER** 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surnema) . Pages 1 and 2 should be file ment of Haath and Mental Hy lant: If Itam 27 fa marked oth-jury or other traumatic evant MARY MARGARET WEBB AUGUSTIN BOYKIN PARKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) P.O. BOX 1474 - OCEANVIEW, DE 19970 KITTY SUE BULL ROSE permit. Pages 1 and Department of Haalth Important: if Itam 27 any Injury or other ti Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burlal 2 Cremation 3 Removal from State 8/20/00 MEARS, VA 4 ☐ Donetion 5 ☐ Other (Specify) WESSELLS CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
THORNTON FUNERAL HOME
24183 CHADBOURNE ST. - PARKSLEY, VA 23421 CARL THORNTON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. AGONAL ASPIRATION **Physician** /Medical Immediate Cause (Final SPIRATION disease or condition resulting in death) Examiner Imonory disease. Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown AND OMETRIA ANCEYZ Records. by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 Yes of Vital 25. Wes cese referred to medicel examiner?

Ves 2 No Be 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To this To the Hospital or Attanding Phy within 24 hours after deeth.

To the Funeral Director: After this completely filled in by the funeral: 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) and manner stated. Medical (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 2000 000 Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) Baltimore Belveden Ave BENDAYAN, MD 2401 West 31 Date filed (Month, Dey, Year) 32. Registrar's Signature AUG 2 4 2000 Registrar

DHMH 16 Rev 6/95

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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

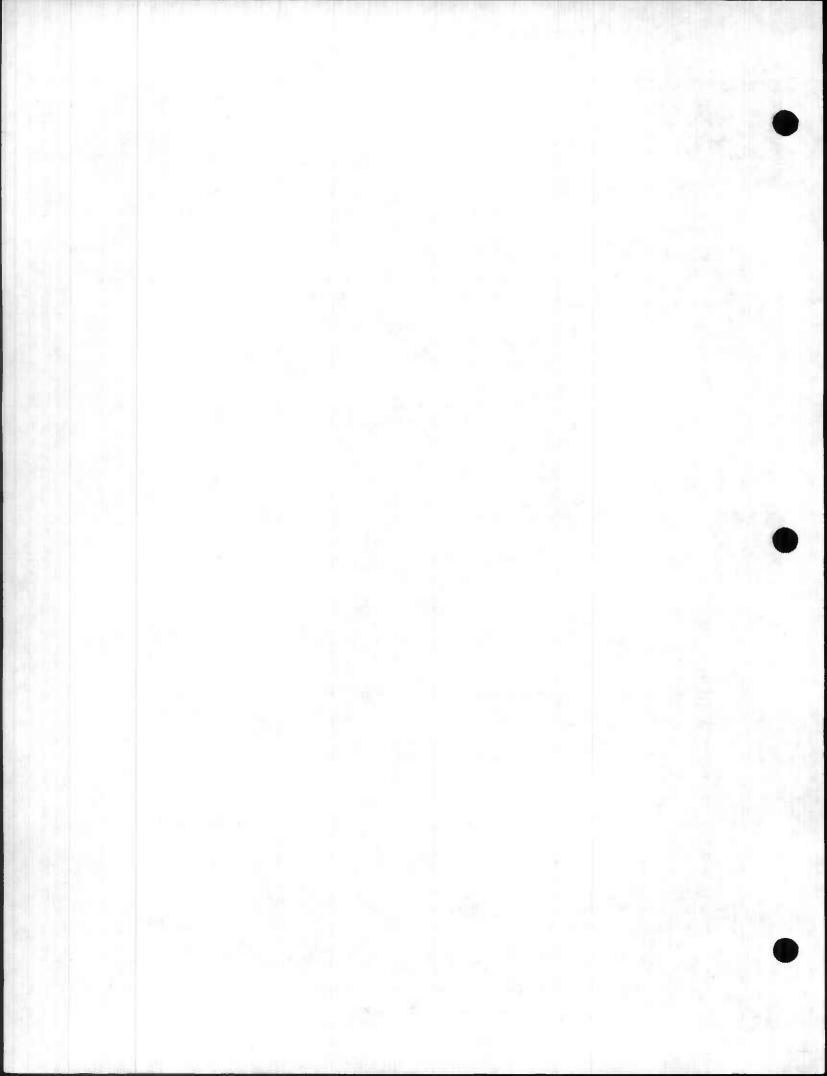
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	Physicia /Medic	_	Sarah E. Christy	SENJEM b		
	Examine			, or Location of Death	4c. County of De	ath
			CHIZENS NUESING HOME HAYEE d	GRACE	HARTO	20
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Maryland	2 sho and 1 la ma	'	19a. Informant's Name/Ralationship (Type, Print)  19b. Mailing Addrass (Street and Number of	or Rural Routa Numbe	er, City or Town, State,	Zip Code)
	1 and 2 Health em 27 I		Mary Woodson / Daughter 138 Vancherie Ct., H	Havre de G	race. MD 2	1078
ore	of He		20a. Mathod of Disposition 20b. Place of Disposition (Nama of	Data	20c. Location - City of	r Town, State
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Baltimore,		1	21. Signatura of Funaral Sarvice Licensee  22. Nama and Addrass of Fecility			
Ö	Departic Importa any Info		disa Scott 552 Lewis Stree	et, Havre	de Grace,	al Services MD 21078
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<u> </u>	din Dir	Certification:	4 Homicida building, etc. (Specify)	City or Tov	vn, Stata)	
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			MANNEL M- LOZZON MD	a rang	- reel	waland of
	State	<b>=</b>	31. Data filed (Month, Dey, Year)  OCT 1 2000  32. Pégistrer's Signetura	Marae	1)10	young
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Cheisly, SARA E.



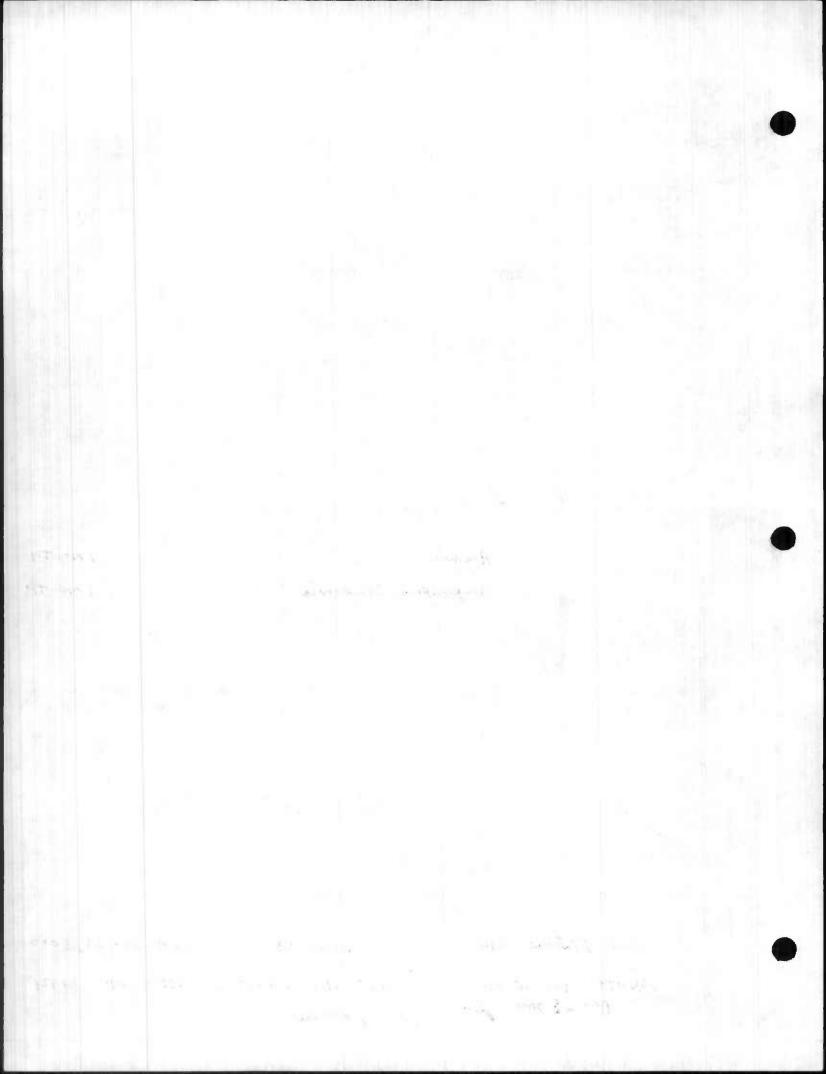
State of Maryland / Department of Health and Mental Hygiene 00 32564

						Certifi	cate of	Death		Reg. No.		1007
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	Physicia		Edmund Philip	Crivello.	Sr.				Septen	ber 24,	2000	2:30 AM
	/Medica	_	4a Facility Name (If not institution, give	· · · · · · · · · · · · · · · · · · ·			- 4	b. City, Town,	or Location of De			
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	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Σ	29b. Signature and title of certifier			K N	29c. Licens	se number		29d. Date signe	d (Month,	Day, Year)
			1 101000	01001	W 13		DL	CEZA		Spateno	514	DAAD.
	10.	1	30. Name and address of person who c	omplated cause of d	eath (Item 23)	a) (Type Print	1 and	2 2 20	)	7	)	, 2000
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	State Registra		SEP 2.6.200	1) Dener	res	1	tir v	1				



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month Year **Physician** Bertha Virginia Cox Sept. 28 2000 2:40 am /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner E1kton Cecil Lauralwood Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days Hours 1□M 200F Months Yrs. Director Oct. 30, 1914 USA 219**-**12-6236 Usuel Residence of Deceden 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 XYes 2 ☐ No Maryland Cecil Chesapeake City ag. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2970 Augustine Herman Highway 21915 United States death Funeral 14. Race - American Indian, Black, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 72 hours after 1 ☐ Yes 2 ▼No If Yes, Give 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 7yrs Homemaker other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 8 If Itam 27 is marked o Thomas Hinson Bailey Pages 1 and 2 should 0 Bertha Virginia Bailey 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Joyce Ann Stansfield 241 Woods Rd. Elkton, Md. 21915 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from Stete 5 permit. Page Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) Pauls Cemetery 10/1/00 Earlyille, Md 22. Neme end Address of Facility Fellows, Helfenbein & Newnam Funeral Home 226 E. Main St. Cecilton, Md. 21913 if the disease, or coneart failure. List op Approximate Interval Between Onset and Death **Physician** /Medical Immediete Ceuse (Finel Anemia disease or condition resulting in deeth) MONTH Examiner Due to (or as a consequence of): Examiner Unspecified Leukenus MONTY physician and s the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as e consequence of): 68760 Physician/Medical Due to (or es e consequence of): attending p Box ed by the detached Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? O signed by to 1 Yaa 2 No 3 Probably 4 Unknown ۵ Records. þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed peen 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attanding Physician: Be 25. Was case referred to medical 26. Place of Daeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 PNatural 5 Pending death. 1 Yes 2 No investigetion 2 Accident ector: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 24 hours after die Funeral Direct 4 ☐ Homicide ò Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steted. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) monte Makous, no September 28,2000 D-44783 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) West High street, ELKTON, MO MAKOUS, MO MONTE 2000 32. Register's Signeture State Registrar



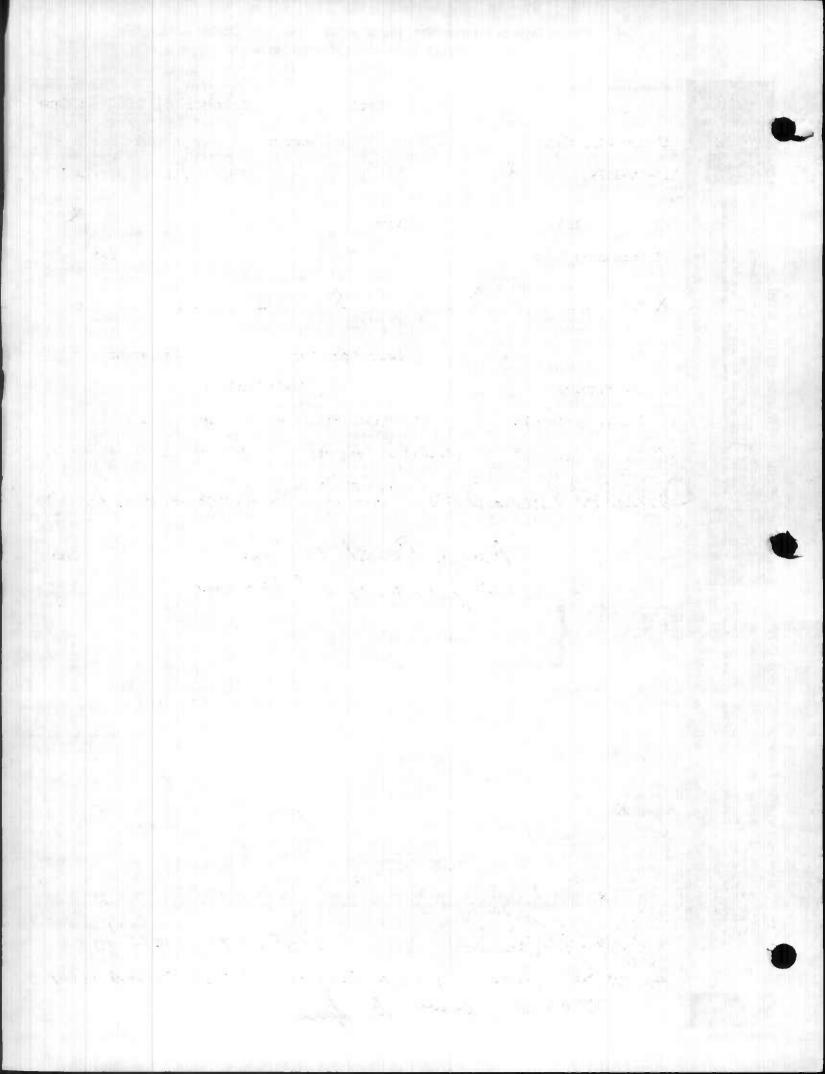
Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day 4 **Physician** 2000 9:35pm Cook October Lena · /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death **Examiner** William Hill Manor Easton Talbot If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral 1□ M 20 F Hours Director 08/08/1911 215-16-6079 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Cifizen of What Country? 21601 501 Dutchmans Lane USA death Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritel Status 14. Race - American Indien, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours efter nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or ite nry or other traumatic event, I'm Medical Examine 1 ☐ Never Married 2 ☐ Married 1□ Yes 2 No altimore, Maryland 21215-0020 Specify: Specify. by 3 Widowed 4 □ Divorced Yeer or Dates: White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Owner/Operator Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Fleming Susie Bradley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 111 Hamlet Hill Road, Baltimore, Md. 21210 Charles T. Gordon/Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition ery, cremetory or other place) 1⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Beechwood Cemetery permit. Page Depertment of Important: If any Injury or 10/7/00 Princess Anne, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, Md. 21853 MANAL Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final 30 disease or condition resulting in death) Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last ue to (or as a consequence of): that the deeth certificate be execu Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) 98 for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the bed signed by the 1 Yes 2 PNo 3 Probabiy 4 Unknown p 24b. Were eutopsy findings eveilable prior to 24a. Was an autopsy performed? Completed peen completion of cause of death? hes page 2 3 NO 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) 1 Yes 2 No To Other: Jursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death funeral 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After or Attending 5 Pending investigation efter death. 1 | Yes 2 | No 2 Accident 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end manner stated. Medical 29a. Certifier (Check only one) To the I within 2 To the F 29d. Dete signed (Month, Day, Year) 29b. Signature apartitle of certific nd address of person who completed cause of death (Item 23a) (Type, Print) 5 Wather for st Easton ms 2160/

State Registrar

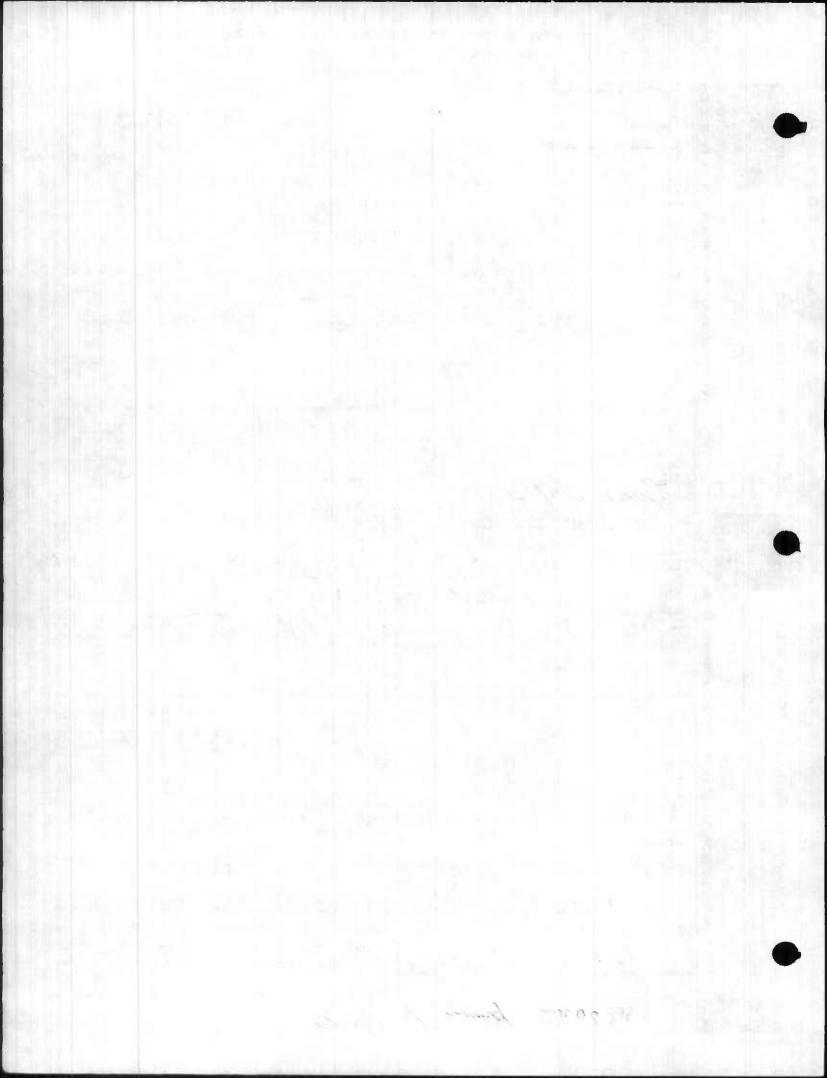
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2000 32. Registra s Signature



State of Maryland / Department of Health and Mental Hygiene 00 32567

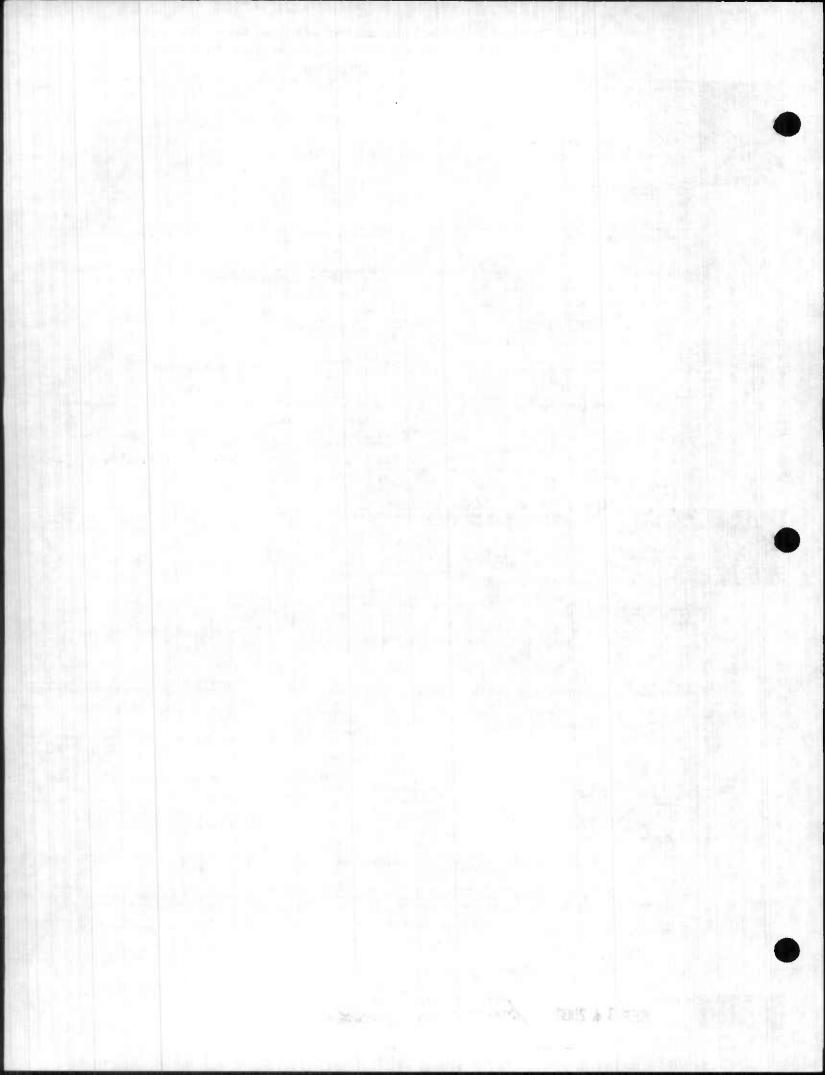
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To the Hospital or Attending Pri, within 24 hours after death. completely filled in by the funeral Medical Certification: 7	one)	and mannar statad.		gonganor		,	30001100 0					
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State of Maryland / Department of Health and Mental Hygiene 0 32568 Certificate of Death

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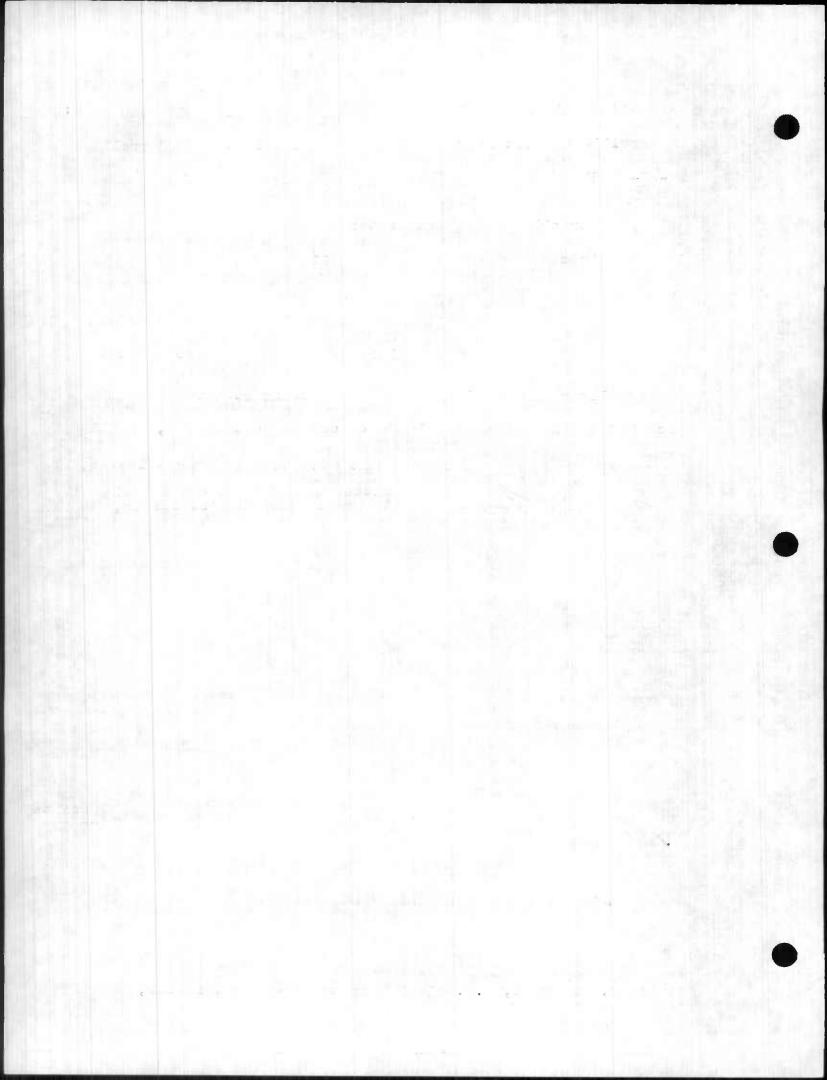
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Day Year **Physician** Marlene Marie Dennis Oct. 2000 01 6:50am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 101 Fairway Court Havre de Grace Harford 5. Social Security Number if Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 7. Age (in vrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Day, Year) Months Days 1 M 2 X F Yrs 60 003-26-7255 08/23/1940 Pennsylvania Usual Residence of Decedent 10a State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Director MD Harford Havre de Grace 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 101 Fairway Court 21078 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify. þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Retail Self-employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William George Mezick Anna Elizabeth Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leroy Dennis- Husband 101 Fairway Ct., Havre de Grace, MD 21078 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Grdns 110/5/00 Aberdeen, MD 22. Name and Address of Facility 21. Signature of Funeral Servica Licenses Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078 23a. Parl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) Physician/Medical Due to (or es e consequenca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. rumman 1 Yes 2 No 3 Probably 4 Unknown di p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 2 000 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) Injury at 28d. Describe how injury occurred 1□ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of injury 28c. Injury at Work? Certification: 5 Pending Investigation Naturai 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State)

the buriel-transit pue physician 98 esn for Division of Vital Records, P.O. the signed by t peeu hes certificate or Attending Physician: efter death. Director: After this certific completely filled in by Hospital 24 hours 24 hours e

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be motified at

parmit. Peges 1 end 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "ready Injury or other traumatic event, it is Med Pares."

**Physician** /Medical

Examiner

the Merylend

death

Baltimore, Maryland 21215-0020

To the To the To the I

State

Registrar

Medical

Walni 31. Date filed (Month, Day, Year)

29b. Signeture end title of certifier

4 Homicide

(Check only one)

29a. Certifier

dol Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

200

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. License number

OCT 3 - 2000

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month Year **Physician** September 37, 3000 4b. City, Town, or Location of Death 4c. County of Death Mary Annabelle Doerr 7:10 AM /Medical 4e Facility Neme (If not institution, give street end number) Examiner Grace Harford Nursing 1+12ens Home If Under 1 Year 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Min. Months Days Hours 1□M 2MF Yrs. 81 Director 212-18-0062 08/08/1919 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo 28s-f Havre de Grace Harford the Medical Examiner must be notifi-10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or Barra 23a or 145 Wilson St. 21078 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Maritel Stetus Black, White, etc. I ☐ Yes 2 X No If Yes, Give 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: White à 3 X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Dan Elementary/Secondery (0-12) College (1-4or 5+) Home Homemaker unknown permit. Pages 1 and 2 should be fix. Department of Heath and Mental Hy Important: If Nem 27 is marked other any Injury or other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Harold Hamilton Alice Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 145 Wilson St., Havre de Grace, MD 21078 Carol Blakeley- Niece 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 Cremation 3 ☐ Removel from Stete 9/28/00 West Chester, PA 4 ☐ Donetion 5 ☐ Other (Specify) Ferris & Co. Inc. 22. Name and Address of Facility iv.itchell-Smith Funeral Home, P.A. 21. Signeture of Funerel Service Licensee WD 21078 123 S. Washington, Havre de Grace, 23a, Pat 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or es a consequenca of) Examiner physician end s the burial-trans Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequença of). edicai Due to (or as e consequence of): 818 for use as Physician/M Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? e g signed by d 1 Yes 2 No 3 Probably 4 Hiknown by 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? peen: completion of cause of deeth? page 2 20 No 1 Yes 1 □ Yes 20 No certificate director Be 25. Was case referred to medical 26. Place of Deeth (Check only one) 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA ihis 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Death Certification: 28b Time of 28c. Injury et Work? Attending 1 Natural 2 Accident 5 Pending investigation 1 TYes 2 No death. Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) after 4 ☐ Homicide 6 To the Hospital or within 24 hours at To the Funerel D 24 hours 8

Records. Vital o Division

Box 68760

altimore, Maryland 21215-0020

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature end title of gr

30. Name and address of pe

**DHMH 16 Rev 6/95** 

eth (Item 23e) (Type Print)

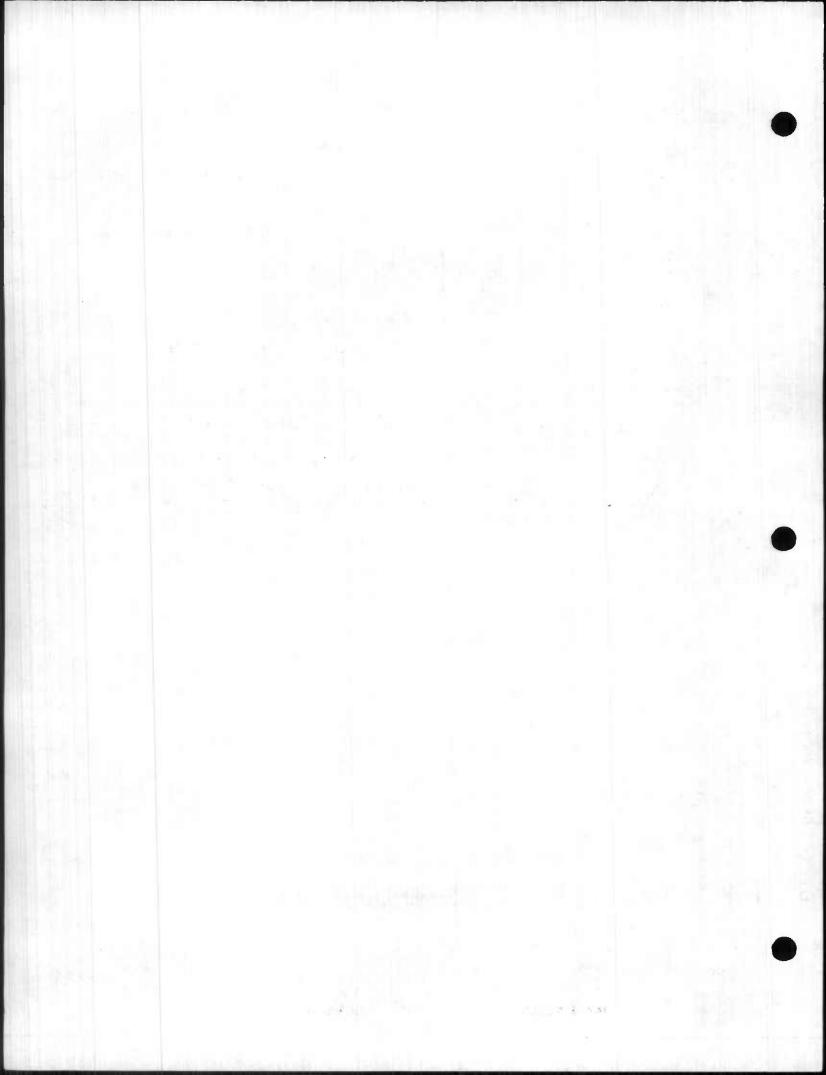
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32. Registrar's Signatur

Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end menner as stated.

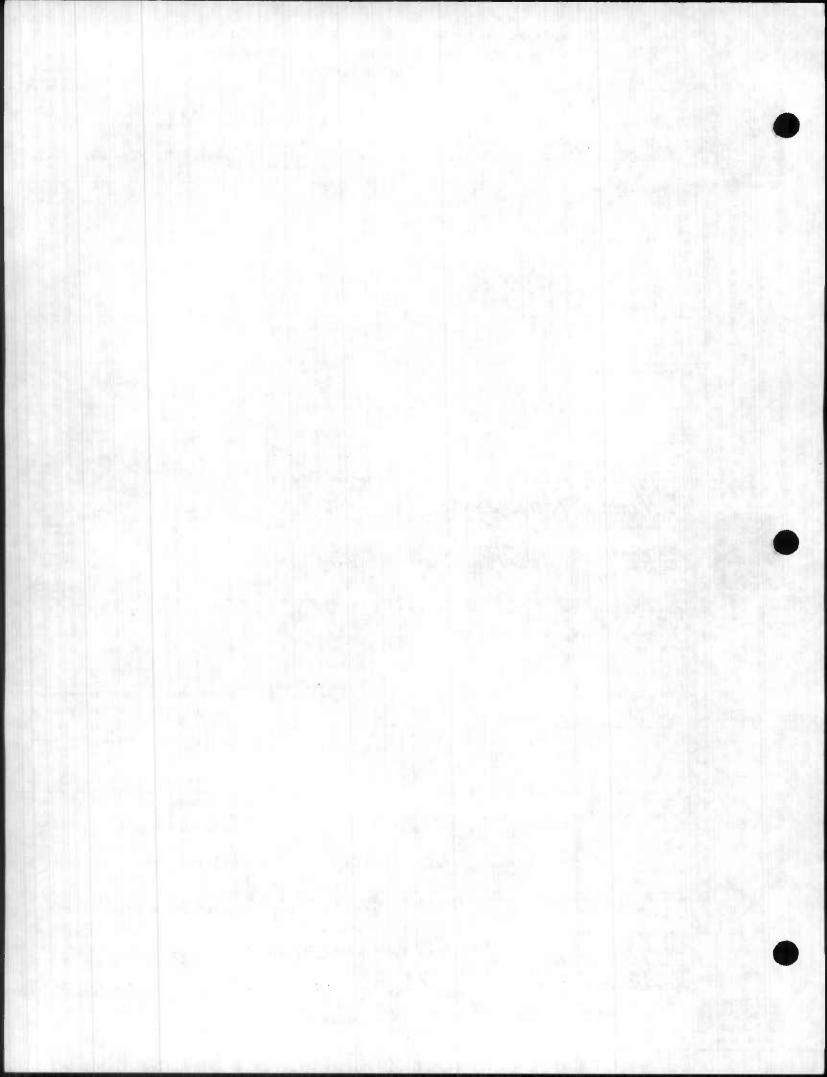
2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)



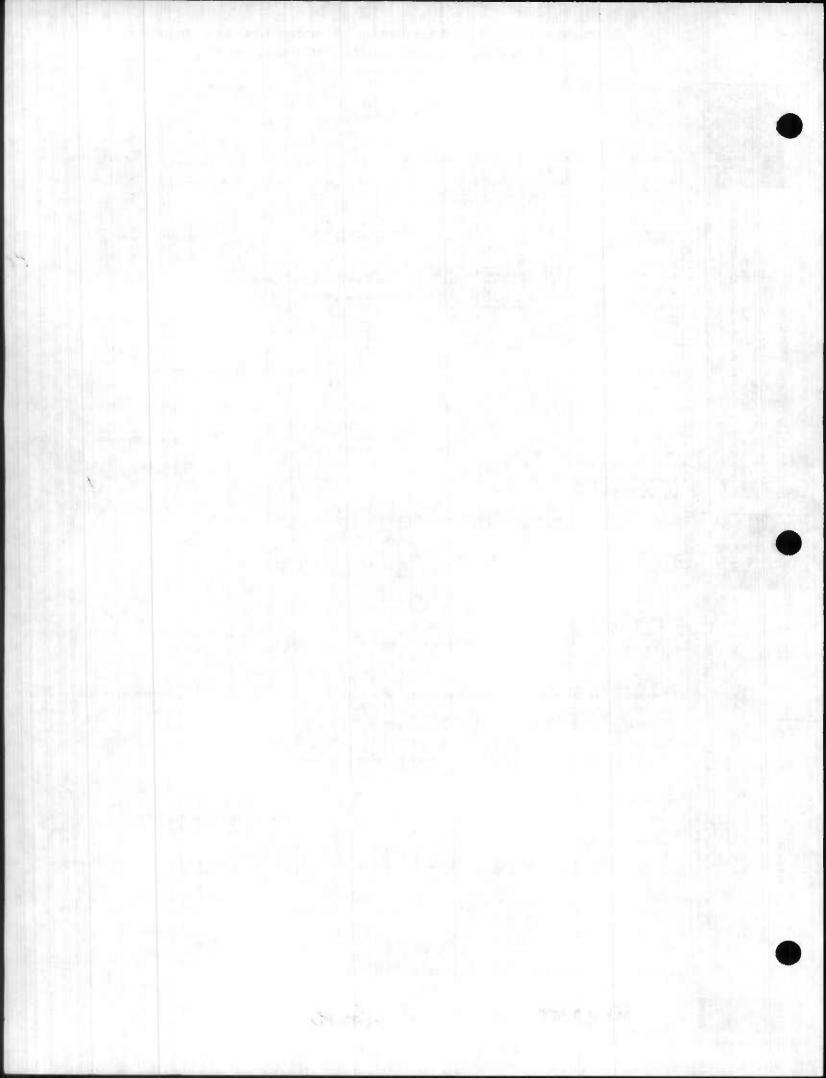
State of Maryland / Department of Health and Mental Hygiene

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	Funeral Director			7. Age (I	n yrs. lest birth Y	nday) If Unc Month	er 1 Year s Deys	If Under 24 Hrs Hours Min		th ly, Year) 1933	9. Birthplace (S Country) MARYLA	ND		
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9	al-tran	Yau	Sequentially list conditions, if any, leading to immediate											
5875U,	physicien and sthe burial-transit	20	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	t										
	0.6	2	Die to for es e consequence of):  Pespiratory Compromise											
. BOX	artificate has been signed by the stending scior, page 2 should be deteched for use as	ALA		Spira	Torcy	P	,			12 1 1 1				
J. 5	the s	ysic	Part II. Other significant conditions conf	ven in Pert I.	23b. Did	tobacco une cor	ntribute to the ca	use of death?						
	detec		Kenal 1RAMSA	plant					12 yes 2 No 3 Probably 4			4 Unknown		
ecords	should be	2 2								en eutopsy	24b. Were autoevailable			
000	2 should	Die							perio	ormed?	completion of death?	n of ceuse		
	certificate has	5							10	Yes 20 No	1 ☐ Yes	2 No		
Or VITA	ector.	90	25. Was cese referred to medicel exeminer?	ospitel:			l Ot	26. Piece of De	eth (Check only	one)				
0	this corral dire	2	1 ☐ Yes 2 No ☐	128e. Dete of Injury	2 ER/Out		DOA	4   Nursing	1 -	how injury occurr				
VISION	Afte o fune		1 Neturel 5 ☐ Pending investigation	(Month, Day Y	ear) In	jury M	28c. fnju Wo	rk? ]Yes 2 □ No	250. Describe now injury occurred					
5 2	그 그 그 그 그		3 Suicide 6 Could not be determined	28e. Piece of Injury building, etc. (	- At home, feri Specify)	n, street, fect	ory, office			281. Location (Street end Number or Rurel Route Number, City or Town, Stete)				
To the Hondtel	within 24 hours To the Funeral completaly filled	leal lead	29e. Cartifier (Check only one)  10 Certifying Phys 2 Medical Examin	ician: To the best of n er: On the basis of ex and menner stete	aminetion end	deeth occurre or Investigati	ed et the ti on, in my	me, date end plec opinion, deeth occ	e, end due to the urred et the time,	ceuse(s) and ma date end plece,	anner es stated. and due to the ca	use(s)		
900	omple omple		29b. Signeture end title of certifier		,			se number		1 -1	d (Month, Day, Y	ear)		
F	· \$ ⊢ ŏ		Machan	Min	Shall	0	10417	K.435M.	12445	Sextens	IR 22.	2000		
			30. Name and address of person who con	mpleted cause of deet	h (Item 23e), (T	ype, Print)		435M	// .	7,000	1			
			CHRISTIAN MINSHALL	225	outh c	speen.	e Sti	noet, BA	Homene	MARRY	Ilard 21	201		
	State	9	31. Date filed (Month, Day, Year)	32. Registrat's	Signeture	4	1			,				



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eg. No.	00	U		J	1	0

				Cer	tiricate	e or i	Death			Reg. No.			, ,
	1. Decedent's Name (First, Mid	ddle, Last)							2. Date of E	Death Day	Yea		e of Death
Physician	E 0 30	Francis	Dvs	on						mber 18			35 p.m
/Medica	to English Name /// and institu			OII		4	b. City, To	wn, or Lo	ocation of Dea		ounty of De		
Examine							Too	nord	town			fary's	
	St. Mary's				if Under	1 Voor	If Under						
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. last	Yrs.	Months	Days	Hours	Min.	8. Dete of E		9. 8	Birthplace (Sta. Country)	te or Foreign
Director	215-64-6014		87	115.					Oct.	1, 191	2 Ma	ryland	
9	Usual Residence of Decedent		1.0 0 =				Y					1	
the sta	10a. State 10b. Cour	nty	10c. City, To	own or Lo	cation								Clty Limits
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with the Marylar a or 28s-f show be notified at	10e. Street and Number				10f. Zip					10g. Citizer	of What	Country?	
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death w	46475 Frank 11. Maritel Status 12 Never Married 2 M		cedent Ever in U.S.	12.1	Man Danad			ining /Co	ecify Yes or I			merican Indian	
o man	11. Mantel Status	Armed F	orces?	13. 1	Yes, spec	ify Cuba	in, Mexica	n, Puerto	Rican, etc.)	14.	Black, W		
3 4 5 4		If Yes, G	2 No	1	□ Yes 2	2 No	Specify.			SI	pecify: W	Thito	
2 2 2 3	3 ☐ Widowed 4 ☐ Divord	ed Year or	Dates:								, V	AIIICE	
od within 72 ho yglene. we than "nature. t, the Medical.	15. Deced	lent's Education hest grade completed		6a. Deced	lent's Usua	l Occup	ation	at of work	tina	16b. Kind	of Busine	ss/Industry	
Me Me	Elementery/Secondery (0-12	1	(1-4or 5+)	life. L	kind of wor OO NOT us	e retired	1)						
The state of	7			F	armer					Agr	icult	ure	
D HEED		le, Last)					18. Moth	er's Nem	e (First, Midd	le, Maiden Su	meme)		
Maryland 21215-UOZU  4 2 should be filled within 72 hours at th and Marital Hyghene. 7 is marked other than "natural", or treurnatic event, the Medical Exam T. De Convoldated by	Phillip Briso	na Dyean					Fra	nces	Cleve	land D	owns		
San F	1112222	-		Ob 11-31-		1011						a Tin Code)	
2 st	19a. Informent's Neme/Relation	onsnip ( <i>Type</i> , <i>Print)</i>		90. Mailin	ig Address	(Street	a <i>no</i> rvumo	er or mur	ai moute ivuii	nber, City or T	JWII, State	e, 21p Code)	
- 5905	James Kenneth	Dyson / 1					Drive	, La		Maryla			
of the contract of the contrac	20a. Method of Disposition	36.0	20b. Place	of Dispos etery, cren	sition (Nen netory or o	ne of ther plac	ce)		Dete	20c. Loca	ion - City	or Town, State	•
semil. Pages 1 Apartment of Hs mportant: If Item my injury or oth	1 ■ Buriel 2 □ Cremation 4 □ Donation 5 □ Other			n1at	e Hea	rt o	of Ma	rv 9	-20-00	Levin	aton	Park,	MD
The state of	21. Settingswer of Furneral Bulyi	1	7 Inmac		. Name an			ity					
D PACE AND	Zekulli	onne	/					Br	insfie	1d Fun	era1	Home,	P.A.
The state of the s	Edward N. Br	insfield,	Jr. M0005	2 22	955 H	lolly	wood	Roa	d, Leo	nardto	wn, MI	20650	-0279
	23a. Pert1. Enter the diseese shock, or heart failure. L	or complications that	ceused the deeth. D	o not ente	er the mod	e of dyin	ng, such as	cardiac	or respiratory	arrest,		Approxi	
Physician :	3113311, 31 113411 1411313.		4	1									nd Death
/Medical	Immediate Cause (Final		At	0								1	/
Examiner	disease or condition resulting in death)	a	y/cm C	10	on	mo	ne	<u> </u>				1 WI	
	5		Due to (or as	e conseq	uence ot):								
executed in end in-transit		b		196								i	
and tran	Sequentially list conditions,		Due to (or as	a conseq	uence of):								
ontificate be executed ding physician end se es the buriel-transit	inat infliated events	c	Due to (or as	a conseq	uence of):								
og ph tifica	resulting in death) Last												
X & Sa		d											
as that the death of gned by the attentioned by detached for u.	5												
D the state of the	Part II. Other significant cond	itions contributing to	death but not resulting	g in the ur	nderlying o	euse giv	en in Part	1.	23b. Di	d tobacco us		ute to the cau	se of death?
T ta d by d be d		trat la	A F.	Mu	11				1[	Yes 20	<b>1</b> 3 □	Probably 4	4 Unknown
S S S S	Comp	f la 10	000 / 11	N CN		-				(			
ecords, lew requires as been sign 2 should be	1/4	60 11	1							as an autopsy	24	b. Wera eutop available pr	sy findings
The lew requir	Aura	will	etter						Po	iioiiiioa i		completion of death?	of cause
Heche he h													1
The The	3			F-3					1[	Yes 2	10	1 ☐ Yes	21000
VITALITY Idelan: The certificate rector, pag	25. Was case referred to medi examiner?	cal					26. Plac	e of Dea	th (Check on)	y one)			(
- K m O	1 ☐ Yes 2 B	Hospital: 1	Inpatient 2 ER/	Outpatien	1 3 DC	Oth	er: 4)49	ersing He	ome 5 Re	sidence 6 [	Other (S	Specify)	
Physical dispersed dispers		28e. Dete	of Injury 28t	b. Time of	2	8c. Injur Wor				e how injury			
or Attending Factors After death.  Director: After din by the funer	1 Natural 5 Pen	ding (Mo	nth, Dey Year)	Injury	М		Yes 2	No					
to dee the start	3 Suicide 6 □ Cou	ld not be	e of Injury - At home.	farm etr	eet factor	office			28f. Location	(Street and i	Vumber o	r Rural Route I	Vumber.
DIVISION C below Attending P is after deeth. at Director: After the led in by the funera	4 ☐ Homicide dete	build build	ding, etc. (Specify)	, 10,1111, 5111	dot, lactory	, once			City or 1	own, State)			
To the Hospital or Attending Phwithin 24 hours after deeth. To the Funeral Director: After th completaly filled in by the funeral													
t hou	29a. Certifier 1 Certif	ying Physician: To the al Examiner: On the	e best of my knowled	dge, death	occurred	at the tir	ne, date a	nd place,	and due to the	e date and o	nd menne	r as stated	se(s)
To the Hospital Within 24 hours To the Funeral completaly filled	one)		mer stated.	andrer mit	Juligotto!!		F	00001	30 31 11 70 1111				
To the To the Company	29b. Signature and title of cert	ifiar			290	. Licens	e number			29d. Date	signed (M	lonth, Day, Yes	ar)
		1					199	17		9/	201	00	
		X		11 -	D. Seri	U	, , ,	- (		/	-		
in		on who completed call								,			
12	James C Boy		3415 Three	e Not	ch R	oad,	Cal:	form	nia, Ma	ryland	206	19	
State	31. Date filed (Month Day, Ye	ar) 2000 32.	Redistrer's Signature	6	-		-						
Registrar	311 1 2	0 2000	- Par	D.	130	are	21						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32574 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** William Dallas Davis, Sr. August 22, 2000 9:05 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Veterans Home Charlotte Hall St. Mary's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 9, 1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 110 M 2□ F 219-12-2875 82 Maryland Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Maryland Directo St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 44430 Clarks Mill Road 20636 Items 23a U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1A1 Yes 2 ☐ No If Yes, Give Year or Detes: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Merried 2 Married "natural", or Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: À 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) 4 th College (1-4or 5+) Electrician U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) and 2 should be fill fealth and Mental H m 27 is marked off 86 Joseph King Davis Mary Adell Raley 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 703, Hollywood, Maryland 20636 Grace Davis / Spouse mportant: If Hem 27 ny injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1KD Burial 2 ☐ Cremation 3 ☐ Removel from State 8/25/00 Charles Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) Leonardtown, Maryland 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Pert1. Enter the disease, or complica shock, or heart failure. A jet only one Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ancen OI Examiner Due to (or es e consequence of) Examiner physician and the burist-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): for use as P.O. Part Il-Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records. p 24a. Was an autopsy performed? 24b. Were autopsy lindings available prior to Completed completion of cause of death? hss 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical transfilled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Mapner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier edical (Check only To the Within 2 To the Complete 29b. Signature and fitte 29c. License number 29d. Dete signed (Month, Day, Year)

State Registrar 30. Name and addly

31. Date filed (Month, Day, Year)

SEP 0 6 2000

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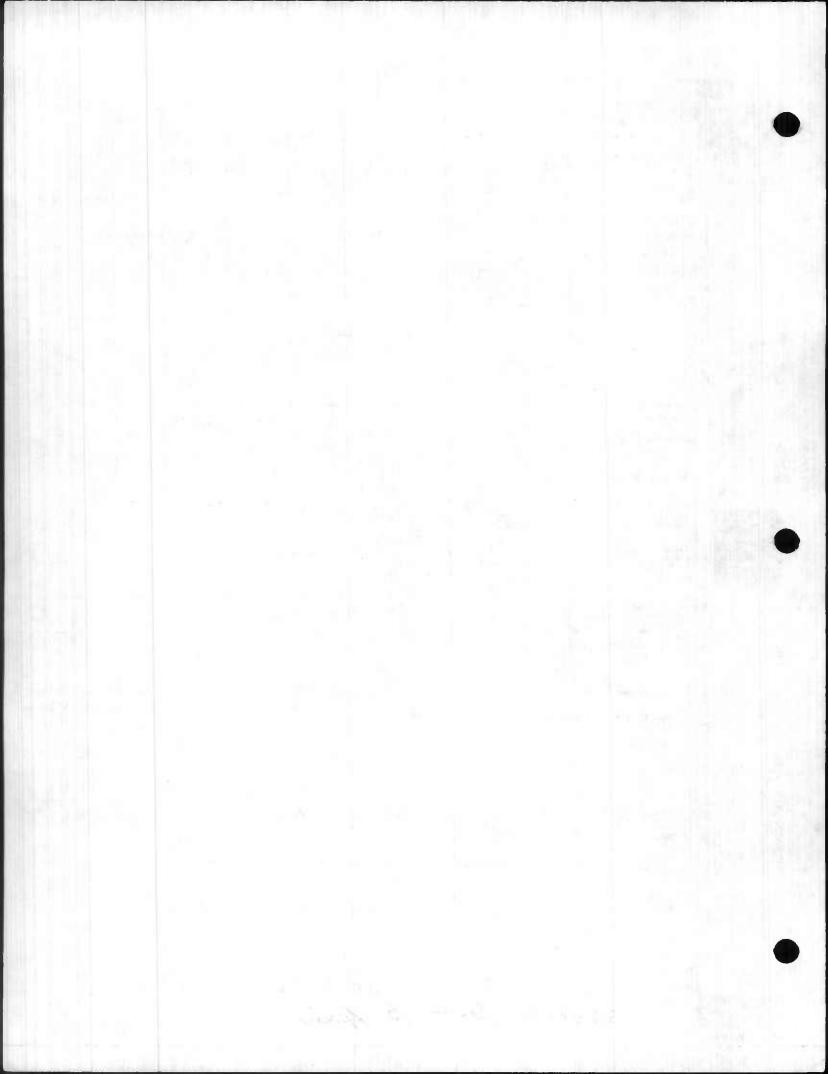
William ( )AVIS

of death (Item 23a) (Type, Print)

32. Registrar's Signeture

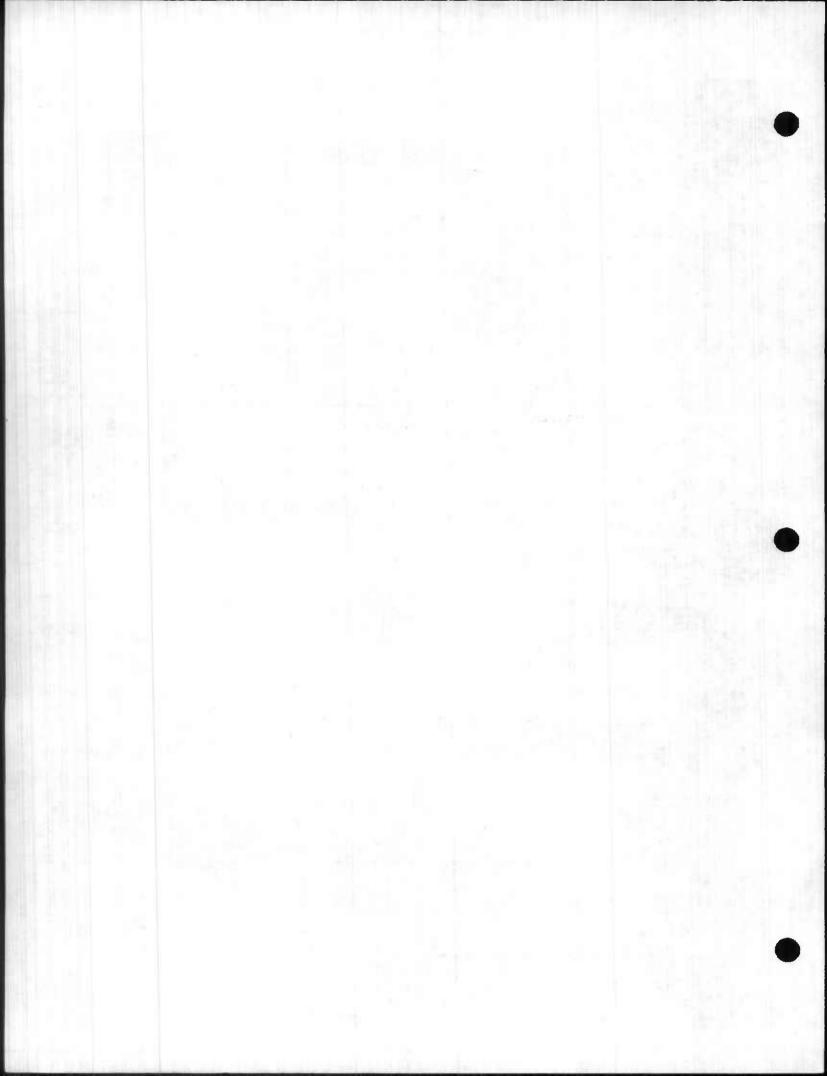
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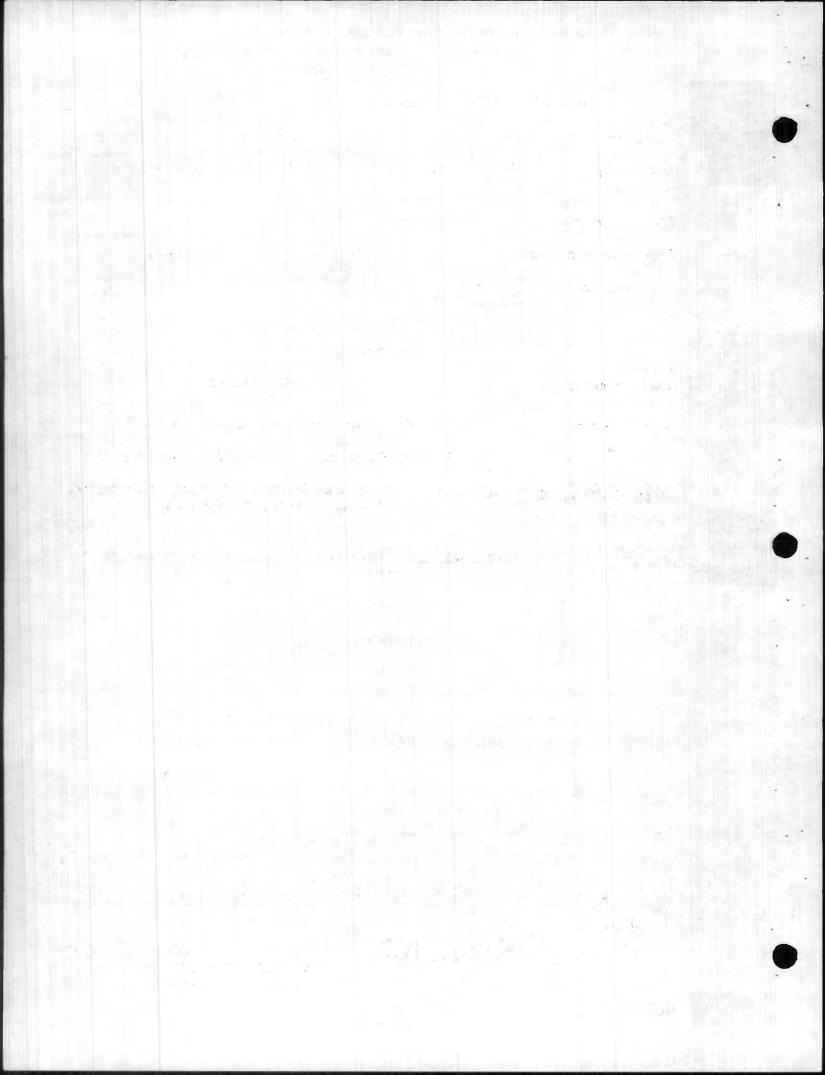
				•	Certificate of		F	Reg. No.	0 32	2575
Physic	ian	1. Decedent's Nama (First, Middla, L					2. Data of Dea Month	Dey	Yaar	Tima of Death
/Med		Robert Elwood En					Septemb			1 p.m.
Exami	ner	4a Facility Nama (If not institution, g 645 Milt DeWitt				4b. City, Town, or Lo Friendsv		4c. County		
(X0)				(In yrs. last birtl	nday) If Under 1 Year	If Under 24 Hrs.				(State or Foreign
Funeral Director		338-18-3617 Usual Rasidance of Decedant	180 M 20 F 75		rs. Months Days	Hours Min.	8. Deta of Birtl (Month, Da) Jan 4,		Country) Illino:	(State or Foreign
B & H		10a. Stata 10b. County		10c. City, Town	or Location	1975 E I C			10d. lr	nside City Limits
Many Many	tor	MD Garrett		Frie	ndsville				1	☐ Yas 2 No
A 28 P	Director	10e. Street and Number		100	10f. Zip Code			10g. Citizen of V	Whet Country?	
9 ml		754 Milt DeWitt	Road		2	21531			USA	
Maryland 21215-0020 of 2 should be tiled within 72 hours after death with the Maryla tith and Montal Hygiene. 37 is marked other than "natural", or thems 23e or 28e-f short theuradic event, the Medical Examiner must be notified at	by Funeral	11. Maritel Stetus  1 ☑ Nevar Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ev Armed Forcas? 12 Yas 2 No If Yas, Give Yaar or Datas:		13. Wes Decedent of Hif Yas, specify Cubo		ecify Yes or No- Rican, atc.)		e - Amarican in ck, Whita, atc. White	dien,
2 hour	pet	15. Decedant's I	Education		Decedent's Usual Occup (Giva kind of work done lifa. DO NOT use retired	pation			usinass/Industry	y
215 mm 7	Completed	(Specify only highast g Elamantary/Secondary (0-12)	College (1-4or 5+	)	lifa. DO NOT use retire	dunng most or work! d)	ing			
Manual N	Con	12 th			ming			Agricul		
D STEP	9e	17. Fathar's Name (First, Middle, Las			i i saida k	18. Mother's Name			ia)	
ylan out be Mental mrked o	2	Lyman Sedwick En					ouise H	-		
Mai 12 sh 12 sh 1 s m		19a. Informant's Name/Ralationship Paul H. Enlow/br			Mailing Addrass (Street					(e)
de Tang		20a. Mathod of Disposition			67 Aiken-Mi Disposition (Nama of	.ller Rd.,	Accide		21520 City or Town, S	Stata
Baltimore, semit. Pages 1 at Department of Hea montant: If Item; ery Injury or other Rice.		1 Burial 2 □ Crametion 3		cematary	, crematory or other pla	∞) Sept 27, 2		McHenr		Jidia
Hing Hind		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice	**	Sally K	un Cem., S		.000	richent	у, нь	
Ba pen		1 Lund	Cumau		Newman Fur 179 Miller	neral Home			21536	
		23a. Part1 Enfor the disease, or conshock, or heart failure. List only	mplications that caused the yona causa on each line	ha death. Do n	ot entar tha mode of dyir	ng, such as cardiac o	or raspiratory an	rast,	App	roximata rval Between sat and Death
Physician /Medical	П	Immediata Causa (Finel								
Examiner	13	disaasa or condition resulting in daath)	0.	nary Fi					i y	ear
	6			-14	onsequence ot):				1	
uted ansit	Examiner	0	D	lmonale	onsequence of):				ı y	rear
58760, licate be executed physician and s the burial-transit	Exa	Sequantially list conditions, if any, laading to immadieta causa. Entar Undarlying Causa (Disease or injury		ua to toi as a ci	orisequence ory.					
68760, ficate be ex physician is the buria	edical	that initiated avants	C	ua to (or as a co	onsequence of):					
		rasulting In daath) Last	l d							
.O. Box (the death certifing by the attending ached for use as	Physician/M		d							
O e de	yslo	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying cause give	ven in Part I.	23b. Dld t	obacco use co	ntribute to the	cause of death?
<b>□</b> 10 10 10 10 10 10 10 10 10 10 10 10 10		Diabetes Melli	tus, Type I	I, Absc	ess right 1	.eg,	X	fes 2 No	3 Probably	/ 4 ☐ Unknown
S 2 2	d by						24a. Was	an autonsv	24b. Wara a	utopsy findings
cord requir	Completed	Deep venous th	rombosis, A	trial f	ibrillation		perfor	med?	complet	le prior to tion of cause
I Rec	dm						.0.		of death	
Vital I		25. Was casa rafarred to medical					1 D Y		1 LI Yes	8 2 No
of Vita Physician: this certific ral director,	o Be	axaminar?	Hospital:	2 ER/Out	patient 3 DOA Oth	26. Place of Death ner: 4 Nursing Ho	. /		nas (Canacitus)	
Phys rrthis eral di	n: To	27. Mannar of Death	28a. Data of Injury	28b. Ti	ma of 28c. Injur		28d. Describe h			
Vision Attending or death. ector: After by the lune	atlo	1 Natural 5 Panding 2 Accident Invastigation	(Month, Day)	rear) In		Yes 2 No				
Division of Attending after death. Director: After d in by the lune	Certification:	3 ☐ Suicide 6 ☐ Could not datarmine	be 28a. Place of Injury building, atc.	y - At homa, fan	m, street, factory, office		28f. Location (S City or Tow		per or Rural Roc	uta Number,
D parage	Cer		- January, atta	(Opcomy)				,,		
Division of Vita within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the luneral director,	edical	29a. Cartifiar (Check only one)  15 Certifying P 2 Medical Exa	hysician: To the best of aminer: On the basis of a and mannar state	xamination and	death occurred at tha tir for investigation, in my o	ma, data and place, a opinion, daath occurr	and dua to tha ded at tha tima, d	cause(s) and ma data and placa,	annar as stated and dua to tha	cause(s)
within 3	¥	29b. Signature and title of certifier	GIV maina state	/	29c. Licens	se number		29d. Data signe	d (Month, Day,	Year)
F 3 F 2		> Maren 18	A 11 1		1 N D26	650		09/	25/00	
		30. Name and address operson who	completed cause of dos	th (Item 23a) /7	101			07/	,	
		Margare A. Kai			arrett High	way, Oakl	and, MD	21550		
St	ate	31. Data filed (Month, Day, Year)	32. Registrar		4 1					
Regist		SEP 2 6	2000	newar	D. 1000	to!				



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					Ce	rtifica	te of	Death		Reg. No.	10 (	325	76
Physic	ian	1. Decedent's Name (First, Middle,		nc 171	ED CII CO	.,			2. Dete of De Month	eth Day	Year	3. Time	of Deeth
/Medi		MADE			ERGUSOI	N			OCT	4 20		9:1	4 PM
, Exami	ner	4a Facility Name (If not institution, and NATIONAL NAVAI			D			4b. City, Town, or BETHES			ty of Death NTGOM	EDV	
· Consul					lest birthday)	If Und	er 1 Year		9 Date of Bir	th			e or Foreign
Funeral Director	H	540-20-9402 Usuel Residence of Decedent	1□ M 20XF		4 Yrs.	Months	Deys	Hours Min.	Feb 23	1926	Oreg	(on	e or Foreign
hend lend		10a. State 10b. County		10c. Cit	ly, Town or Lo	ocation					1	0d. Inside	City Limits
Meny Per sh	tor	VA Fairfa	ζ.	Mo	Lean							1 🗆 Y	es XX No
or 28	Director	10e. Street and Number					ip Code			10g. Citizen o	Whet Cour	ntry?	
eth w	ral	7018 Statendam (	-			1	101			U.S.A.			
21215-0020 d within 72 hours after death with the Meryland giene. If then "natural", or ferma 23a or 28a-f show if the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force: 1	s? \$No			edent of I ecify Cub 2 No	Hispenic Origin? (Sean, Mexican, Puert Specify:	pecify Yes or No o Ricen, etc.)	BI	ace - Americ eck, White, ify: Whit	etc.	
	eted	15. Decedent's (Specify only highest)	Education grade completed)		16a. Dece	dent's Us	ual Occupork done	petion during most of world)	rking	16b. Kind of	Business/in	dustry	
d 21215 filed within 7 Hygiene. ther than "n	Completed	Elementery/Secondary (0-12)	College (1-4o	r 5+)		<i>во кот</i> nema		d)		Own H	ome		
		17. Fether's Name (First, Middle, La	st)		11011	icina	RCI	18. Mother's Ner	ne (First, Middle				
ylan buid be Mental arked o	To Be	Eben Pomeroy						Helen	Bethell				
S S E E		19a. Informent's Neme/Relationship	(Type, Print)	mic	19b. Maili	ng Addre	ss (Stree	t and Number or Ru	ıral Route Numb	er, City or Tow	n, Stete, Zip	Code)	
		Jackie Ferguson						m Court,	McLean				
Pages 1 en sent of Heal nt: if item 2 nry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from Stat		Placa of Dispo cemetery, crea	matory or	other pla		Date	20c. Location			
timent tant: i		4 ☐ Donation 5 ☐ Other (Spe	city)	Po	otomac				10/9/00	Dale C	ity, V.	A	
Baltimore, permit. Pages 1 e Department of Hee important: if item any injury or othe		21. Signature of Fuperal Service Lic	- 12	038	77	A Die	mific	ess of Facility  d Funeral	& Crem	ation Se	ervice	, Inc.	
E MANAGE		23a. Pert1. Enter the disease, or co shock, or heart tailure. List or	mplications that caus	ed the deat	th. Do not en	1840 ter the mo	de of dy	lar Drive ng, such es cardia	Triangle or respiretory e	rrest, 2	2172	Approxin	nete
Examiner pue	Examiner	disease or condition resulting In deeth)  Sequentially list conditions, if any leading to immediate	a. <u>AORTI</u>	Due to (d	LUSION or as a consec or as a consec	quence of	):	JERE CORO	NARY AR'	TERY DI	SEASE		
f od fou, rificete be executed ng physician end es the buriel-trensit	edical E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last	c	Due to (c	or es e consec	juenca of	):						
5 0 0	n/Me		■ d										
. 0 .0	sicia	Part II. Other significant conditions	contributing to death	but not res	sulting In the u	nderlying	cause gi	ven in Part I.	23b. Did	tobacco uae o	ontribute to	o the caus	e of death
es that the de igned by the e	/ Physician/M								10	Yes 2 No	3 ∑ Pro	bably 4	Unknow
ecord sw requir	Completed by								24a. Was	an autopsy ormed?	av	ere autops vailable prid empletion of deeth?	or to
The The sate he page	Con								10	Yes 200 No	1[	□Yes 2	!□ No
ysician: The scentificate director, pag	Be	25. Was case reterred to medical examiner?	Hoonital:				100	26. Place of Dec	ath (Check only	one)		100	
2 the sea	2	1 ☐ Yes 2 ☒ No  27. Manner of Deeth			ER/Outpatier		JUA		forme 5 ☐ Res	dence 6 🗆 O		<i>'y)</i>	
Ing Ing	tion	1 DNatural 5 Pending 2 Accident investigat	28a. Date of In (Month, I	ay Year)	Injury	M	28c. Inju Wo 1	rk? ]Yes 2□No	20d. Describe	now injury occ	urred		
or A fred in by	Certification:	3 Suicide 6 Could not determine	280. Place of I	njury - At h etc. (Specil	ome, farm, sti	reet, facto	ory, office		28f. Location ( City or To	Street end Num wn, State)	n <i>ber or F</i> lura	al Route N	um <i>ber</i> ,
To the Hospital or within 24 hours effer To the Funeral Dir completely filled in	edicai C	29a. Certifier (Check one)  1X Certifying 2 ☐ Medical Ex	Physician: To the bes aminer: On the basis and manner	ot examina	wledge, deet ation and/or in	h occurre vestigatio	d et the ti	me, dete end plece opinion, death occu	e, and due to the urred at the time,	cause(s) and a date and place	manner as a a, and due to	tated. o the caus	e(s)
To the To the Comp	×	29b. Signature and title of certifier	211	)		2	9c. Licen	se number		29d. Date sign	ned (Month,	Day, Year	7)
		Mary	WKO	Crow	M	2	D-3	3036 (TX)		10 -	5-	00	
		30. Name and address of person	completed cause of	death (Iter	n 23a) (Type,	Print)		NATIONAL		MEDICAL	CENT		
		GARY D. KET ON 31. Date tiled (Month, Day, Year)			nhuro			BETHESDA	MD 208	89-5600			
Sta	ate	OCT 1 6 2000	he see Hegis	trar's Signa	ALUI O								

DHMH 16 Rsv 6/95



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MIcha	ael C	Charles	Ford
amend	item	23a, 27, 2	8a,b,c,d

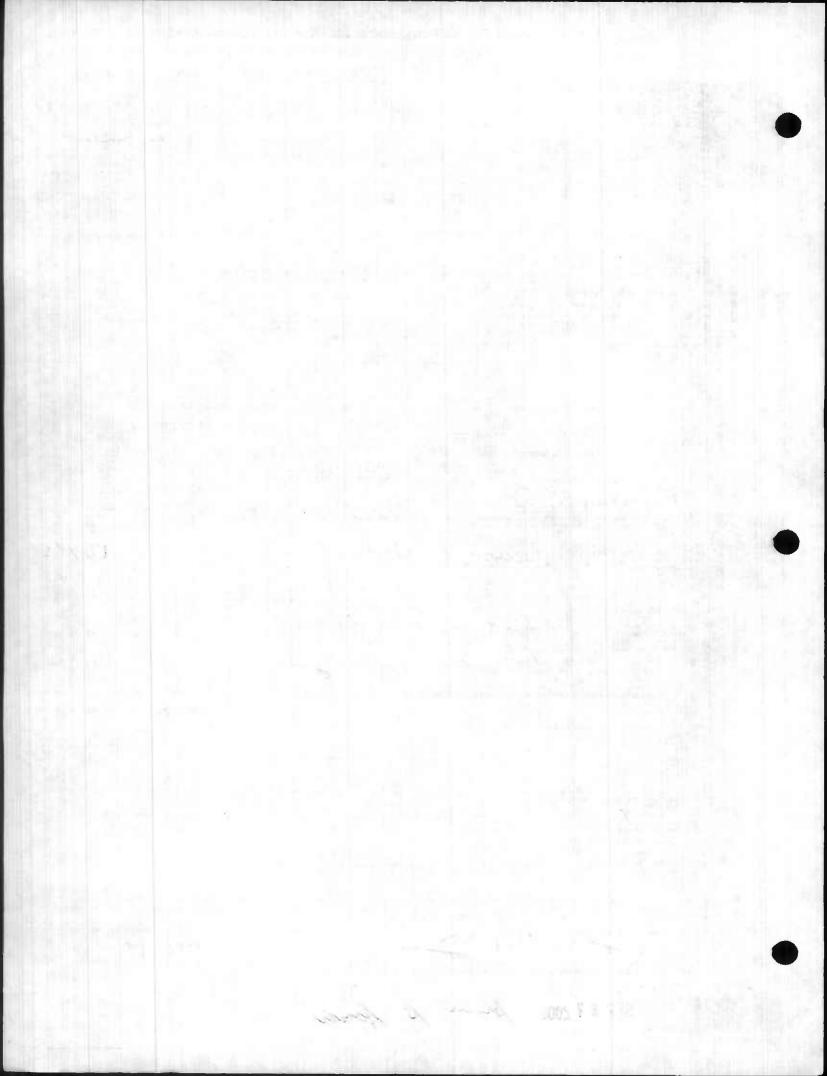
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23a,27	7,28a,b,c,d,e,f per me	G788 10/17/00	yf	Certifica	te of	Death	F	leg. No.		0 1 1
hysician	1. Decedent's Neme (First, Middle,						2. Date of Dee	th Dey	Year	3. Time of Death
/Medical	Michael Charles						October		000	11:19 P.
xaminer	4a Facility Name (If not institution,					4b. City, Town, or		- 0.		
		ndel Medica	L Cente In yrs. last bin		er 1 Yeer	Annap	Olis		Arur	
neral ector	217-58-4456		•	Yrs. Month:				25, 195	1 So	ace (Stete or Foreign try) uth Dakota
	Usuel Residence of Decedent  10a. State 10b. County	1	Oc. City, Town	or Location					10	Od. Inside City Limits
To To	M 1	undel	An	napolis						1 Yes 2 No
at be notified at	10e. Street and Number 300 A Forbes S	treet			ip Code 1401			10g. Citizen of V		•
Example: must be notified at by Funeral Director	3 □ Widowed 4 □ Divorced	12. Wes Decedent Ev Armed Forces? 1 1 Yes 2 No If Yes, Give Yeer or Dates:	er in U,S.			Hispenic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Rad Blee Specify	e - America ck, White, e Whi	etc.
went, the Medical Exp Be Completed by	15. Decedent's (Specify only highest : Elementery/Secondary (0-12)	Education grade completed) College (1-4or 5+)	16a.	Decedent's Us (Give kind of v life. DO NOT Roofer	ual Occu ork done use retire	pation during most of world)	rking	16b. Kind of B		
S O	12			Rooter			(E) . A ! ! ! !			OII
To Be	17. Father's Neme (First, Middle, La George W. Ford	st)					me (First, Middle, n Newton	Maiden Sumen	10)	
r trauma	19a. Informant's Name/Relationship Marian Ford / Mo					St. Anna			Stete, Zip	Code)
important; it field of 1 is marked other train mature any injury or other traumatic event, the Medical pace.  To Be Completed	20a. Method of Disposition  1  Burial 2  Cremation 3 4  Donation 5  Other (Spe		Pt. Li	Disposition (Ny, crematory of NCOIN	eme of cother ple crema	itory	Date 10/10/00	20c. Location - Brentw		
any inju	21. Signature of Funeral Servica Lin	ens66								Home, Inc MD 21401
Aedical Examiner	disease or condition resulting in death)  Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse, (Disease or injury	b	ue to (or as a	OL INTOX	i):	ON				
for use as the b	resulting in death) Last	C	ue to (or as a d	onsequence of	):					
hed for	Part II. Other significant conditions	contributing to deeth but	not resulting in	the underlying	cause gi	iven in Part I.	23b. Dld 1	obacco use co	ntributa to	the cause of death
be detached for use by Physician/							10	Yes 2□ No	3 Prot	Dably 4 Unknow
should should					١.	كجند	24a. Wes perfo	an autopsy med?	ava	ere autopsy findings ailable prior to mpletion of cause death?
Page Com							1)2(1	res 2□No	18	Syes 2□ No
director, page 2	25. Was cese referred to medical examiner?	1.0					ath (Check only o	ne)		
	1 X Yes 2 No		2 ER/Ou	•	JUA		fome 5 Resid			
funar	27. Menner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Dey)		ime of njury nown M	28c. Inju	iry at ork? ] Yes 2 [3(No	28d. Describe	now injury occur	red uni	cnown.
Completely filled in by the funaral Medical Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	be on place of lains	unkr y - At home, fa (Specify)				28f. Location (3 City or Tow Annapolis	Street and Num. m, Stete) 30	ber or Rurs A Fot	Poute Number,
stely fille		Physician: To the best of a aminer: On the basis of e end menner state	xamination an							
Me	29b. Signeture and title of Cartifier	C. C Monnor State	. ,	2	9c. Licen	se number		29d. Dete signe	ed (Month,	Dey, Year)
- 5	1	M. Ci	4			O.C.M.E.			37.51	, 2000
	30. Name and address of person w	o completed cause of dea				t, Baltim				

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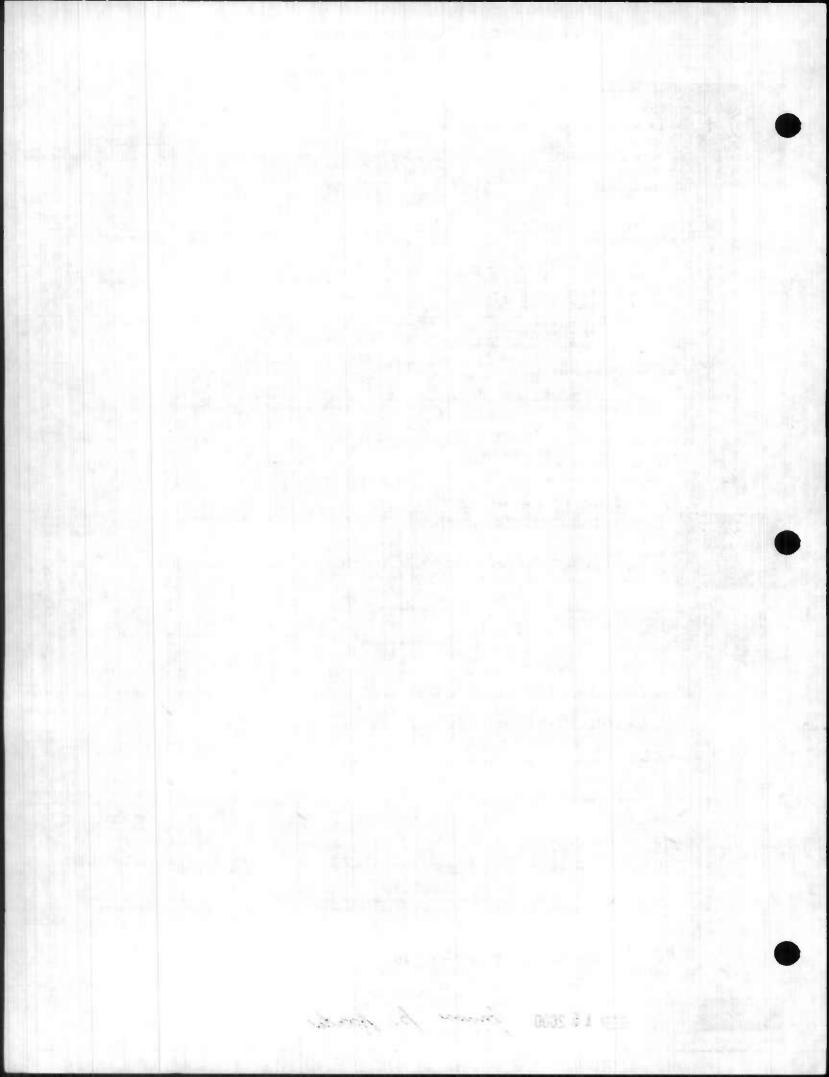
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	Certific	ate of Death	Reg.	. No.	12010
HOH	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
hysician	Helen Julia Fleissne	r	Septembe:		8:50 AM
ledical aminer	se Facility Neme (If not Institution, give street and number)	4b. City, Town, or		4c. County of Deeth	
	29923 Crosswoods Drive	Mechanics	sville	St. Mary	's
1	5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If U	nder 1 Yeer If Under 24 Hrs hs Days Hours Min.			e (State or Foreign
r	201-01-7288	hs Days Hours Min.	January 18	B, 1912 Penns	ylvania_
	10a. Stete 10b. County 10c. City, Town or Location			10d	. Inside City Limits
ō	Maryland St. Mary's Mechanics	ville			1 ☐ Yes 2 No
ecto		Zip Code	100	. Citizen of What Country	2
ā					
ara	29923 Crosswoods Drive  11 Merital Status 12. Wes Decedent Ever in U.S. 13. Was D	20659	Spooifu Vos os No	USA	Indian
Fune		ecedent of Hispenic Origin? (S specify Cuben, Mexican, Puer	to Rican, etc.)	Black, White, etc	
à	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detas:	s 2 No Specify:		Specify: Whi	.te
g,	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind o	Jsual Occupation work done during most of wo	dking 16	b. Kind of Business/Indus	stry
Completed	Elemantary/Secondary (0-12) Collega (1-4or 5+)	Tuse retired)	, king		
100		ht Agent		Railroad	
Be C	17. Fether's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, Mai	iden Sumame)	
TOB	Mike Zidik	Mary	0	nderick	
-	19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Add	rass (Street and Number or R	ural Route Number, C	City or Town, State, Zip C	ode)
	Frank McDonough (Son) 14608 Wh	arf Road, Acco	okeek. Mar	vland 20607	
	20a. Method of Disposition 20b. Placa of Disposition	arf Road, Acco	Dete 20	c. Location - City or Towr	n, State
	1 ☑Burial 2 ☐ Crametion 3 ☐ Ramoval from State	or other placa) Cemetery	0 /05 /0000 =		M - 3 - 3
	4 Donation 5 Other (Specify) Immaculate Hear  21. Signature of Funeral Service Licenses 22. Nam	t of Mary	9/26/2000 1	exington Park,	Maryland
Examiner	Immediate Cause (Final disease or condition resulting in death)  Due to (or es a consequence b. ALZ heims.	es CXA		0	itérical Between inset end Death 5 XRS
Exar	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	on:	2		
edical	that initiated events resulting in death) Lest	of):		Λ.	
5	Cor Susuff	my_		L	ulen
an	d	8			
Physician/	Part il. Other eignificant conditions contributing to death but not resulting in the underlyi	ng cause given in Part I.	23b. Did toba	acco uss contributs to ti	he causs of death?
by Phy			1 Yes	2 No 3 Proba	bly 4 ☐ Unknow
Completed			24a. Was an a performe	ed? availe	a autopsy findings able prior to pletion of cause ath?
Eo			1□ Yes	2 No 1 1	Yes 2 No
	25. Was case raferred to medical	36 Place of Dr	eath (Check only one)		
o Be	examiner? Hospital:	Other:	,	ca 6 Othar (Specify)	
-	27. Manner of Death 28a. Dete of Injury 28b. Time of		28d. Describe how		
Pol	1 Netural 5 Panding (Month, Day Year) Injury	28c. Injury at Work?			
Certification:	2 Accident Investigation 3 Suicide 6 Could not be detarmined 28a. Placa of Injury - At home, farm, street, fabuilding, etc. (Specify)		28f. Location (Stree City or Town,	et and Number or Rural I Stata)	Route Number,
edicai	29a. Certifier (Check only one)  1⊠ Certifying Physician: To the best of my knowledga, daath occu 2□ Medical Examiner: On the best of axamination and/or invastige and manner stated.				
Me	29b. Signeture and Ullian Logistary	29c. License number	29d	d. Date signed (Month, De	sy, Year)
	( ome shi M)	D 15000	9	126100	
		D 15032		11	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1	1 20626		
		wood, Marylan	na 20636		
tate	31. Date filed (Mark), Payorey 2000 32. Prigistrar's Signature	1			



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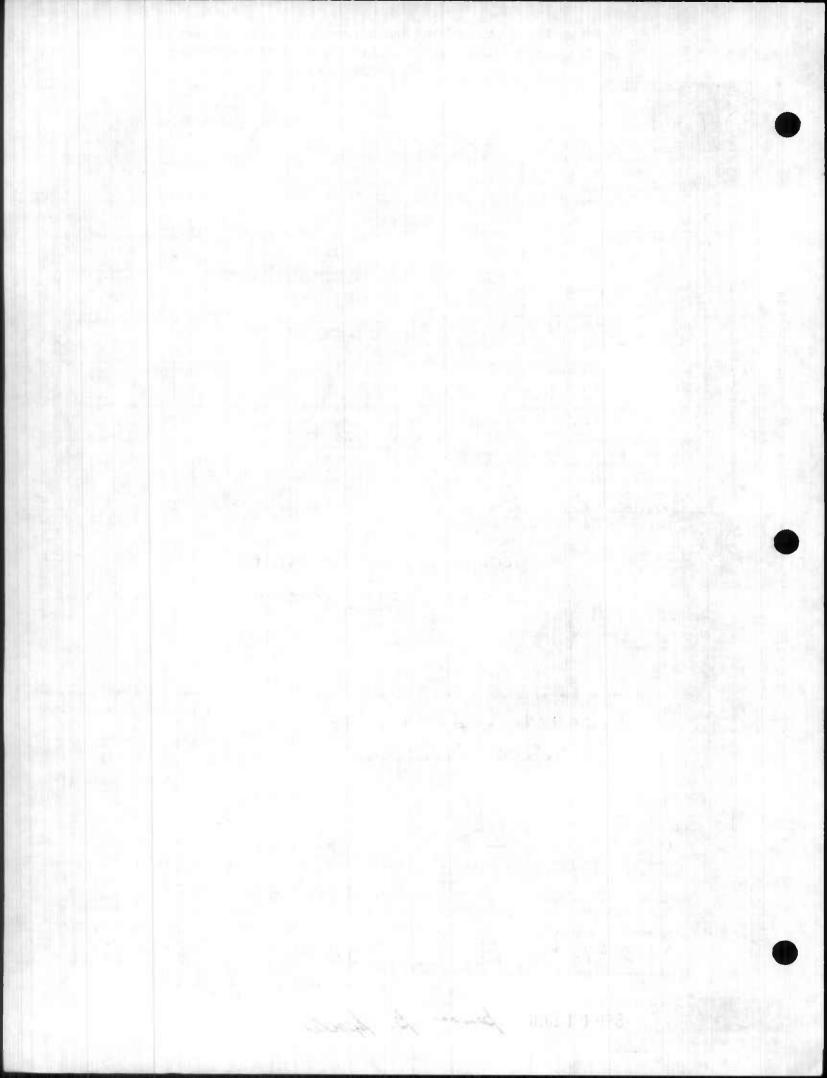
	4 December Name (First )											Reg. No.		
Physician	Decedent's Name (First, Fig. 1)	Middle, Las	st)				1				2. Dete of D Month	Dev	Yeer	3. Time of Deat
Physician /Medical	James		Everett		F	arre	211				Septer	mber 14,	2000	7:15 P
Examiner	4e Facility Name (If not insti	and the same of		2301				4	b. City, To	wn, or Lo	cation of Dea	th 4c. Count	y of Death	
	St. Mary's	Nurs	ing Cer	nter					Leon				Mary	'S
Funeral	5. Social Security Number	6. S	ex SOM 2□ F	7. Age (In	yrs. last bii		If Under 1 Months	Yeer	If Under Hours	24 Hrs. Min.	8. Dete of Bi (Month, D	rth ey, Year)	9. Birthp	lace (Stete or Fore
Director	220-16-4321		MM ZUF	78		Yrs.					June 2	3, 1922		yland
2 2	Usual Rasidance of Decedar 10a. State 10b. Co			10	c. City, Tow	m or Loca	ation						1	0d. Inside City Lin
at at a	100.00	Joney			o. oxy, ron		4(10)11							1 ☐ Yes 2 ☑
or 28a-fr be notifies Directo		. Ma:	ry's		Bus	shwoo					_	40 000		
D Be	10e. Street and Number	. D	7				10f. Zip (		110			10g. Citizen of		itry?
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thems 23 siner must	11. Meritel Status	Mar and a d	12. Was Dec Armed F	orces?	r in U,S.	13. 99	es, specif	fy Cube	n, Mexica	n, Puerto	ecify Yes or N Rican, etc.)	Bis	ce - Americ ick, White,	
by F	1 ☐ Never Married 2 ☒ 3 ☐ Widowed 4 ☐ Divo		If Yas, G Yeer or I	2 No		10	☐Yes 2	<b>∑</b> No	Specify:			Specia	fy: TATH	nite
		edent's Ed		Deles.	169	Decede	nt's Usual	Occup	ation	1		16b. Kind of B		
oc with 72 ho ygiene. we then fratur 4, the Medical Completed	(Specify only h	ighest gra	de completed,		104	(Give ki	nd of work	done d	during mos	t of work	ing	TOO. KING OF E	, 43, 103, 411	addity.
Page of the bare	Elementary/Secondary (0- 12th Grade	12)	College	(1-4or 5+)			chin					Civi	1 Ser	vice
	17. Father's Neme (First, Mid	ddle, Last)							18. Moth	ar's Name	(First, Middle	, Maiden Sume	me)	
c ever	William	John	nson	I	Farrel	1			Mar	tha	]	Louise		Graves
M DE L	19a. Informant's Name/Rela						Address	(Street				ber, City or Town		
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Adele O. Farr			2)								Maryla		
Head	20e. Method of Disposition		(-pouse		20b. Plece o	f Disposi	tion (Nem	e of		-	Dete	20c. Location		
0 = 0	1 ☑ Buriel 2 ☐ Creme 4 ☐ Donation 5 ☐ Oth					*	atory or off					Duch	M box	المحد [معددا
100	21. Signature of Funeral Ser				Sacre									aryland
Day and	61 . 0	02	14	0 -								cal Home		
200 ALC: 1	23a. Pert1. Enter the disees shock, or heart feilure.	291	Har	din	ev							n, Maryl	and 2	Approximate
nin isi			R vs		0									171
physician end s the bunial-transit	Sequantielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	{	6. C	LL	to (or as a	consequ								6-7 day
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14 hours after death.  Funeral Director: After this certificate has been signed by the ettending physicis tely filled in by the funeral director, page 2 should be detached for usa as the builded in by the funeral director, page 2 should be detached to use as the builded in by the funeral director. To Be Completed by Physician/Medical	Cause (Diseese or Injury thet initiated events resulting in death) Last  Pert II. Other significant con  Augustus  25. Was cese referred to me axaminar?  1   Yes   2   No  27. Manner of Deeth 1   Neturel   5   Price   Pric	anditions conditions and an analysis and analysis analysis and analysis analysis and analysis analysis analysis and analysis analysis analysis analysis analysis analysis analysis analysis analysi	d	Due  Due  Due  Inpatient of Injury rith, Day Yelling, atc. (S	2 ER/Ot resulting in the control of	conseque conseque n the unc trima of Injury arm, stree	ance of):  ence of):  derlying ce  3 □ DO/  M  et, factory,	Use giv	26. Placeer: 4 November 26. Placeer: 4 November 2 December 2 Decem	a of Deat	24e. Wa per 1 Location City or To	yes 2 No ona) sidence 6 Ot how injury occur (Street and Num	3 Prol 24b. We ever coo of 1 [ ther (Specifiered	bably 4 Unker ere autopsy findin alleble prior to mpletion of cause daath?  Yes 2 No  No  No  No  No  No  No  No  No  No
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State of Maryland / Department of Health and Mental Hygiene 00 32580

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	Decedent's Neme (First, Middle, Last)		= 1				ate of Death	Dev	Yeer	3. Time of Death
Physician /Medical	Beacie	Farris						29, 200		2:56 PM
Examiner	4a Fecility Neme (If not institution, give street and nur	n <i>ber)</i>		- 1	b. City, To	wn, or Locatio	n of Deeth	4c. County 0	of Death	
	45975 Fox Chase Drive	Apt. 414				Mills		St.	Mary	7's
uneral rector	5. Social Security Number 420-58-0467 6. Sex 1□ M 2 ☐ F	7. Age (In yrs. last bii 56	Yrs. If Under	Deys	If Under: Hours	Min. Fe	ete of Birth donth Day, X	8, 1944	9. Birthpl Alar	ece (State or Foreig try) AMB
	Usuel Residence of Decedent  10a. Stete 10b. County	10c. City, Tow	n or Location						11	Od. Inside City Limit
sho sd at			Great M	:110						1 □ Yes 2 🕅 N
acto	Maryland St. Mary's			p Code			100	. Citizen of W	hat Cause	tm.2
23a or 28a-f sho kat be notified at ral Director	45975 Fox Chase DRive A	ot. 414		2063	1			U.S.A.	riet Couri	ayr
xaminer mu by Funer	11. Meritel Stetus  1 Never Merried 2 Married  1 Never Merried 2 Married  1 Yes If Yes, Giv	2 No	13. Was Dece If Yes, sp		lispenIc Origin, Mexican Specify:	gin? (Specify n, Puerto Ricar	Yes or No- n, etc.)		, White,	en Indien, etc. ack
tod	15. Decedent's Education (Specify only highest grade completed)	16e	Decedent's Usi (Give kind of w	uel Occup	ation	t of warking	16	b. Kind of Bus	siness/Ind	lustry
Comple	Elementary/Secondary (0-12) College (1	-4or 5+)	Homemak	use retired	d)	t of working		Own Ho	mo	
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To Be	17. Fether's Neme (First, Middle, Last)  Timothy Farris					er's Neme <i>(Fin</i> ortha Ba		noen Sumame	"	
	19e. Interment's Neme/Reletionship (Type, Print) Jacquelyn Fowler (Daugh		. Meiling Address 5802 N.	,						Code) MD 20619
an an an	20e. Method of Disposition  1 □ Burial 2 ☒ Cremetion 3 □ Removel from 4 □ Donetion 5 □ Other (Specify)	State cemete	t Disposition (Nory, crematory or colitan	other pla			-	c. Location - ( lexandr		wn, Stete Virginia
Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest	Due to (or es e	consequence of	2	Lise	cire				yrs.
by Physician/	Part II. Other significant conditions contributing to de	eath but not resulting i	n the underlying	cause giv	ven in Part f		23b. Did tob	acco ues con	tributs to	the cause of deat
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Completed by	Myocardis Digheres	Mel	ectu	1			24a. Wes en parforme	autopsy ed?	CO	ere eutopsy findings eilable prior to mpletion of cause death?
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e Com	25. Was cese referred to medicel				26. Place	e of Deeth (Ch	eck only one	, ,		/(-
director.	examiner?  12 Yes 2 No Hospitel: 1 1	npatient 2 ER/O	utpetient 3 0	OA Oth	or.		11	ce 6 Othe	r (Specif	y)
funeral c	27. Menger of Death 28e. Dete	of Injury 28b.	Time of Injury	28c. Inju	y at	28d.	Describe how	injury occurr	ed	
ed in by the funera Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	ot injury - At home, to	М	1 🗆	Yes 2	28t. I	Location (Stre City or Town,		er or Aura	I Route Number,
completely filled in b	29e. Certifier (Check only one)  Medical Examiner: On the be end meni	best of my knowledge asis of examination en ner stated.	e, deeth occurre	d at the ti	me, dete en ppinion, dee	nd plece, and o	due to the ceu	ise(s) and mai e end plece, s	nner es si and due to	tated. the cause(s)
Mec Mec	29b. Signature and title of certifier	1	2	c. Licens	se number		290	d. Date signed	(Month,	Day, Year)
6	· m/m	fam		11	1280	-		8-30	-a	3
	30. Name and address of person who completed cous William Boyd, II, M			ardt	own,	Maryla	nd 2065	50		
State	31. Dete filed (Month, Day, Year) 32. R	egistrer's Signeture	,	,						
Registrar	SEP 0 1 2000	Severa	B. 1	lon	Va.					

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32581 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** MARGARET LOUISE GARNER Sept. 30 2000 2340 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Westminster Nursing & Convalescent Center Westminster Carroll County If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** 1 M 2 F 219-14-8101 Director Dec. 14 1923 Maryland Usual Residence of Decedent the Meryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at Maryland Carroll County Taneytown 1 X Yes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 32 Fairgrounds Avenue 21787 United States Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education completed) Pagas 1 and 2 should be filed within 7 nant of Haalth end Mental Hygiena. Int: if item 27 is marked other than "r Elementery/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Oliver Lambert Lola Haines 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Steven L. Garner / son 2725 Crouse Mill Road Taneytown, Maryland 21787 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Oct 20c. Location - City or Town, State permit. Pagas Department of Important: If it any Injury or o 1 XBurial 2 Cremation 3 Removal from State Taneytown, Maryland Trinity Lutheran Cemetery 4 Donation 5 Other (Specify) 2000 21. Signature of Funerel Service Licensi 22. Name and Address of Facility Skiles Funeral Home M01072 136 East Baltimore Street Taneytown, MD 21787 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner bunial-transit and Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting In death) Last cartificata be axec physician as the burial Physician/Medical 88 for usa 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. tha signed by t 1 Yes 20 No 3 Probably 4 Unknown ģ 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? has cartificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel examiner? Be 26. Plece of Death (Check only one) Other: Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatlent 3 DOA Certification: To 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

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Division of Vital Records, P.O. Box 68760, or Attending Physician: after daath. Hospital 24 hours a Funeral D

Registrar

edicai

Natural

2 Accident 3 Suicide

4 Homicide

(Check only one)

29a. Certifier

d address of person who completed ceuse of death (Item 23a) (Type, Print) 2 31. Date filed (Month, Day, Year)

OCT 0 2 2000

5 Pending

investigation

6 Could not be determined

TON 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes

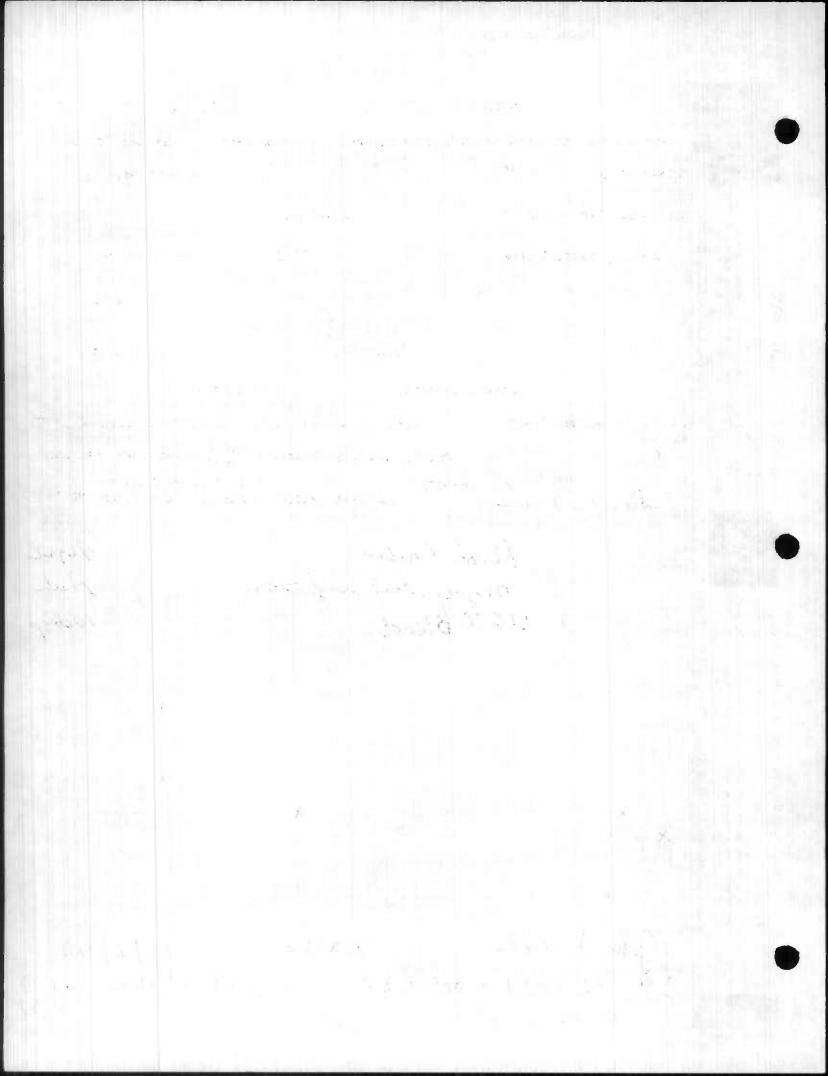
29c. License number

Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

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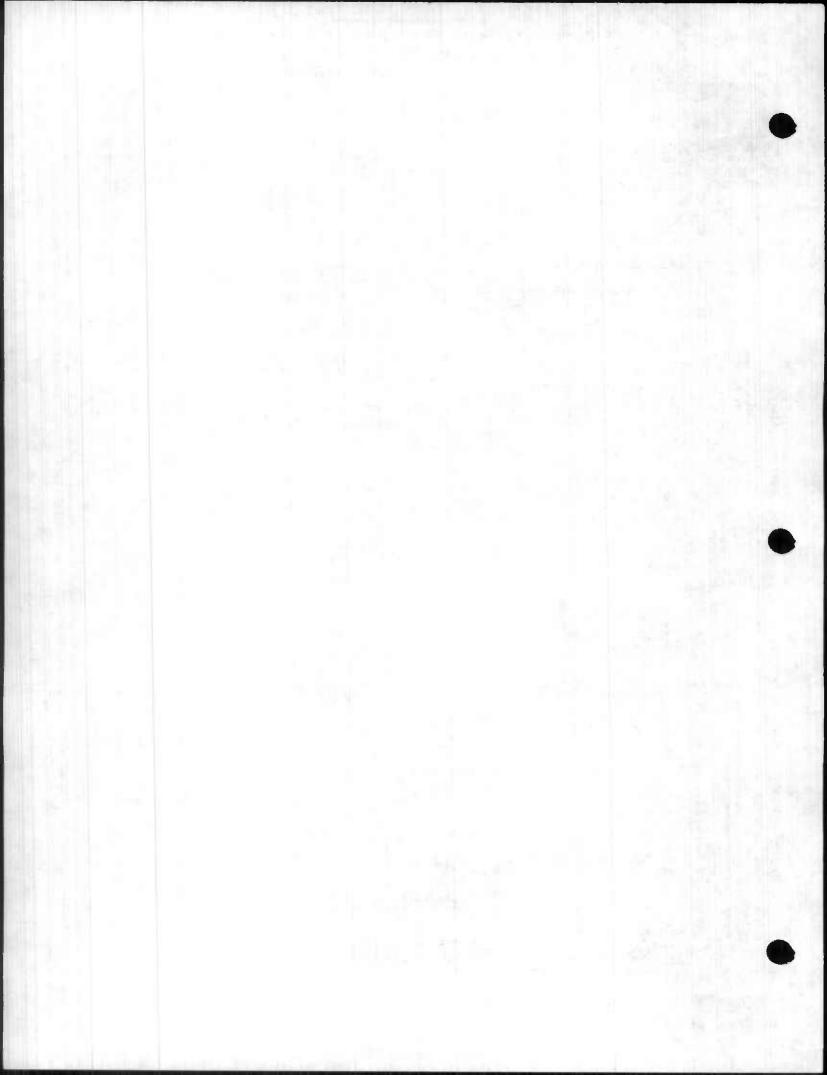
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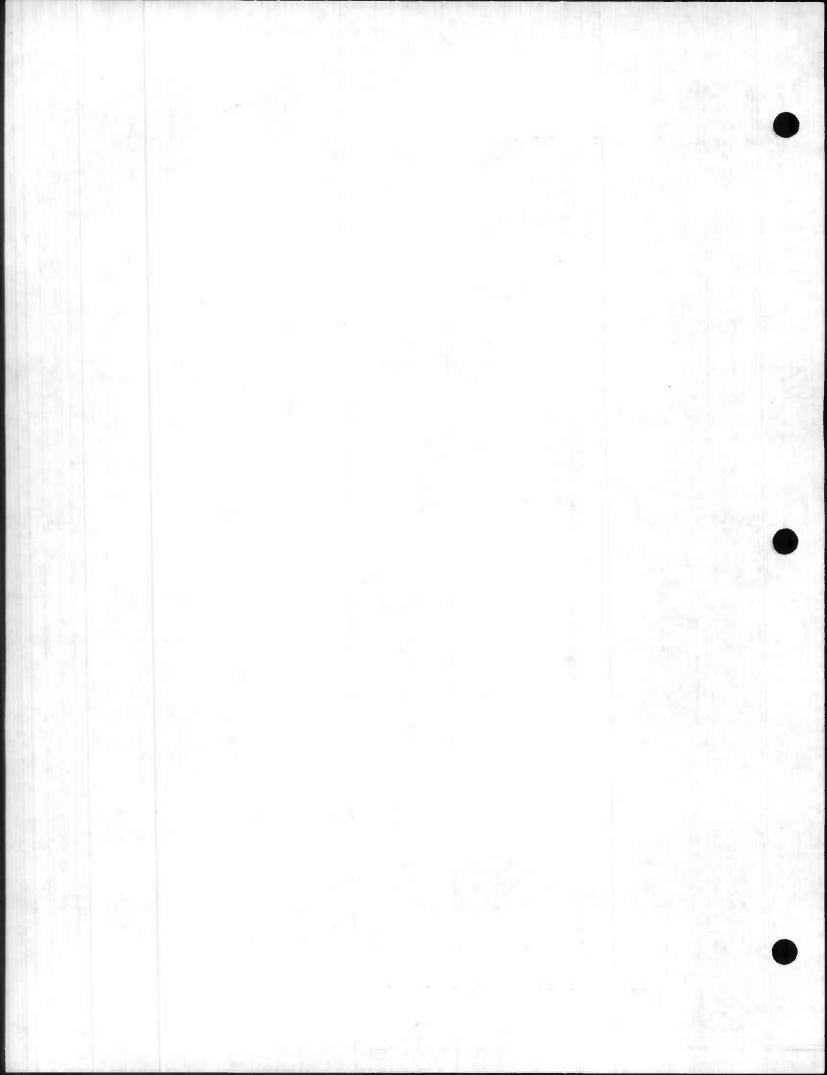


State of Maryland / Department of Health and Mental Hygiene ( ) 2250

4a Facility Name (If not institution Civista Medical  5. Social Security Number  265-05-9517  Usual Residence of Decedent  10a. State 10b. Count  MARYLAND CI  10b. Street and Number  6592 ELLENW(  11. Marital Status  1 Never Married 2 Marital Status  3 Widowed 4 Divorce	MOR GARCIA on, give street and numb Center  6. Sex 1 M 2 F  7. WAY HARLES  DOD DRIVE  12. Was Deceded Armed Force 12. Yes, Give yes, Giv	Age (In yrs. last to 83  10c. City, To ant Evar in U.S. as?  ARMY S: WWII	Wn or Location  10f. Z  13. Was Dec If Yes, sp  X Yes  ia. Decedent's Us (Give kind of wife. DO NOT	LA  ip Code  206  edent of Hispa ecify Cuban, N 2 No Si  ual Occupation ork done during use retired)  PENTER	PLATA	Date of Birth (Month, Day, Yes or No-an, etc.)	4c. County of Charles  ar) 1917  Citizen of Wh U.S	Year 2:4 of Death S 9. Birthplaca (Ste FLORID 10d. Insid 117 hat Country?	A le City Limits Yas 2 □ No
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11. Marital Status  1 □ Never Married 2 ☑ Ma  3 □ Widowed 4 □ Divorce  15. Decede (Specify only high Elamentary/Secondary (0-12)  17. Father's Nama (First, Middle ANTONIO GAR(  19a. Informant's Name/Ralation KATHERINE GA  20a. Method of Disposition  1 □ Burial 2 ☑ ramation	12. Was Decede Armed Force Armed Force No. 19 Sept 2 If Yes, Give Year or Date ent's Education est grada completed)  College (1-4 2 2 a., Last)  CIA nship (Type, Print)	as? ARMY ARMY ss: WWII  or 5+)	ia. Decedent's Us (Give kind of w life. DO NOT	edent of Hispa ecify Cuban, N 2 No Si ual Occupation rock done durin use retired) PENTER	nic Origin? (Specify flexican, Puarto Ric pecify:PUERT n ng most of working	O RICO	14. Race Black, Specify:	- American India , White, etc.	٦,
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19a. Informant's Name/Relation KATHERINE GA  20a. Method of Disposition 1 Burial 2 X remation	nship (Type, Print)								
KATHERINE GA  20a. Method of Disposition  1 Disposition  2 Caracteristics			Oh Bilaitina Balalan	na (Street and	Numbar or Rural R	ENA AM		State Zin Code)	
20a. Method of Disposition 1 Burial 2 Cramation	AKCIA-SPUC	LC L		E AS #		DDIE NUMBER, CIL	y or Town, 3	nara, zip cooa/	
1 Burial 2 Cramation			of Disposition (N			Date 20c.	Location - C	City or Town, Stat	0
4 Donation 5 Other /	3 Ramoval from Sta	came	tary, cramatory or	other place)					
					ATORY 1	0-5-00	ALEX	ANDRIA	, VA.
21. Signature of Funeral Service	e Licensee MOO	179		and Address of	'UNERAL	CEDVIC	E D A		
Mucha	el Kan	nuc	V					•	
23a. Part1. Enter the disease, o shock, or heart failure. Lit	or complications that caused only one cause on each	sed the death. Do	o not enter the mo	ode of dying, s	uch as cardiac or re	spiratory arrest,		Approx	imate I Batween
								Onset	and Death
Immediata Cause (Final disaase or condition	PE	RICA	RDI	AL	EF	FUSI	ON	DA	ZY
rasulting in death)	a		a consequance of						13
Sequentially list conditions, if any, leading to immediate cause. Enter I lead by income									
Sequentially list conditions,	0.	Due to (or as	a consequance of	j):					
Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initiated events								1	
that initiated events resulting in death) Last	6.	Due to (or as a	a consequenca of	):			1.00		
	d							1	
Part ff. Other significant condit	tions contributing to deat	h but not resulting	in the underlying	cause given in	n Part I.	23b. Did tobac	co use cont	tributs to the car	use of death
LODE	10 8-	+EN	2120	7		1 Yss	2□ No	3 Probably	4 Unknow
FORT		1							
								availabla p	rior to
							131129	completion of death?	of cause
						1□ Yes	20000	1 □ Yes	2□ No
25 Was case referred to medic	paf			26	Place of Death //		-74-		
examiner?	Hospital:	ation! 2 \(\sigma\) EB#	Outpationt 3 7	Othor			e E TOthe	r (Specify)	
1 Yes 2 XNo	28a. Data of	Injury 28b	. Time of						
1 Yes 2 No 27. Manner of Death	ting (Month,	Day Year)	Injury M		2 🗆 No				
27. Manner of Death	stigation	Injury - At home,	farm, street, facto	ory, office	281	Location (Stree	t and Numbe	or or Rural Route	Number,
27. Manner of Death  1 Natural  2 Accidant inves  3 Suicide 6 Could	d not be	atc. (Specify)				City or Town, St	tate)		
27. Manner of Death  1 Natural 5 Pend 2 Accidant inves 3 Suicide 6 Could	d not be 28a. Place of	, (		d - 4 4 - 4'	data and place, and	dua to the caus	a(s) and man	ner as stated.	
27. Manner of Death  1 Natural 5 Pend inves  2 Accidant 6 Could  4 Hornicide deter	d not be mined 28a. Place of building		ga. daath occurre	d at tha tima. (		at the time dat-	and place, ar	nd due to the car	(2)021
27. Manner of Death 1	d not be mined 28a. Place of building cling Physician: To tha be at Examiner: On the basi	est of my knowlad	ga, daath occurre and/or Investigation	on, in my opinio	on, daath occurred	at the time, date			
27. Manner of Death  1	d not be mined 28a. Place of building ring Physician: To tha be at Examiner: On the basi and mannar	est of my knowlad	and/or Investigation	on, in my opinio	on, daath occurred		Date signed	(Month, Day, Ye	
27. Manner of Death  1 Natural 2 Accidant 3 Suicide 4 Homicide  29a. Certifier (Check only 2 Medica	d not be mined 28a. Place of building ring Physician: To tha be at Examiner: On the basi and mannar	est of my knowlad	and/or Investigation	on, in my opinio	on, daath occurred	29d.	Date signed		ar)
27. Manner of Death  1	d not be mined 28a. Place of building ling Physician: To the bast and mannal and mannal line.	est of my knowlad s of examination a r stated.	and/or Investigation	on, in my opinio	on, daath occurred	29d.	Date signed		
27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier 30. Name and address of person	d not be mined 28a. Place of building physician: To the bast and mannal and m	est of my knowlad s of examination a r stated.	2 (Type, Print)	on, In my opinion  9c. License nu  D—   4	on, daath occurred	29d.	Date signed		ar)
27. Manner of Death  1	itigation d not be mined 28a. Place of building physician: To tha base and mannarian who completed cause of MD P.O. Box 16.	est of my knowlad s of examination a r stated.	2 (Type, Print)	on, In my opinion  9c. License nu  D—   4	on, daath occurred	29d.	Date signed		ar)
	examiner? 1 Yes 2 No 27. Manner of Death	27. Manner of Death 1 Natural 5 Pending investigation 2 Accidant investigation 3 Suicide 6 Could not be determined	examiner?  1 Yes 2 DNo Hospital: 1 Inpatient 2 EPV  27. Manner of Death 1 Natural 5 Pending investigation 2 Accidant Suicide 6 Could nint be 28a. Place of Injury - At home.	examiner?  1 Yes 2 No  Hospital: Inpatient 2 EP/Outpatient 3 Inpatient 2 Accident 3 Inpatient 2 Accident 3 Input Inpatient 3 Input I	examiner?  1 Yes 2 No  Hospital: Inpatient 2 EP/Outpatient 3 DOA Other:  27. Manner of Death 1 Natural 2 Accidant 3 Suicide 4 Homicide  1 Could not be determined  28a. Place of Injury - At home, farm, street, factory, office  29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, of the country of the countr	examiner?  1 Yes 2 No  Hospital: Inpatient 2 EP/Outpatient 3 DOA  Other: 4 Nursing Homa  27. Manner of Death 1 Natural 2 Accidant 3 Suicide 4 Homicide  1 Could not be determined  28a. Place of Injury At home, farm, street, factory, office  28f. Injury M 1 Yas 2 No  28a. Place of Injury - At home, farm, street, factory, office  28f. Injury M 28d. Injury At home, farm, street, factory, office	25. Was case referred to medical examiner?    1	25. Was casa rafarred to medical examiner?    Yes   2	25. Was casa rafarred to medical examiner?    Towns   Pending investigation

State Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month 09 2000 9:30 AM 25 Elwood Lawrence GROVES 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street end number) 4c. County of Deeth 320 Shenandoah Avenue Loch Lynn
If Under 1 Year | If Under 24 Hrs. | 8 Date 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) 6. Sex 7. Age (In yrs. lest birthdey) Months Deys Min. 151M 2□ F Yrs. 220-16-7122 75 Sept. 8, 1925 West Virginia Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d, inside City Limits 1 ☑ Yes 2 ☐ No Garrett Loch Lynn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 320 Shenandoah Avenue 21550 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 MYes 2 No If Yes, Give Yeer or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2 TNo Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Installer/Repairman Telephone Company 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Carson Bruce Groves Pearl Virginia Hershman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Doris M. Groves/Wife 320 Shenandoah Ave., Loch Lynn, Maryland 21550 of Disposition (Name of 20c. Location City or Town, State 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Garrett Co. Mem. Gardens 9/28/00 Oakland, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Stewart Funeral Home 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Ceuse (Final e renal failure disease or condition resulting in deeth) 4 wks Due to (or as a consequence of): diabetes mellitus, type II yrs Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): atherosclerotic cardiovascular disease yrs Pert II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown chronic obstructive pulmonary disease 24b. Were autopsy findings eveilable prior to 24a. Wes en eutopsy performed? peripheral vascular disease completion of ceuse of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No 28e. Dete of Injury (Month, Day Yeer) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated. (Check only one) 2 Medicel Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D30035 09-25-2000 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

6 items 23a

'natural', or

al Hygiene.

12 should be fill h end Mental H ie marked oth

permit. Pages 1 and 2: Department of Health ei Important: If Item 27 ie any injury or other trau 00009.

**Physician** 

Examiner

end -trer physician the buriel

for use es

ed by the detached

signed b

page 2 :

lal or Attending Physician: The offer death.

Is bleector: After this certificated in by the funeral director, pe

To the Hospital or within 24 hours eft To the Funeral Di completely filled in

certificate be executed

Box 68760.

O

Records,

Vital

of

Division

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

event, the Medical

72 hours efter

Baltimore, Maryland

Director

Funeral

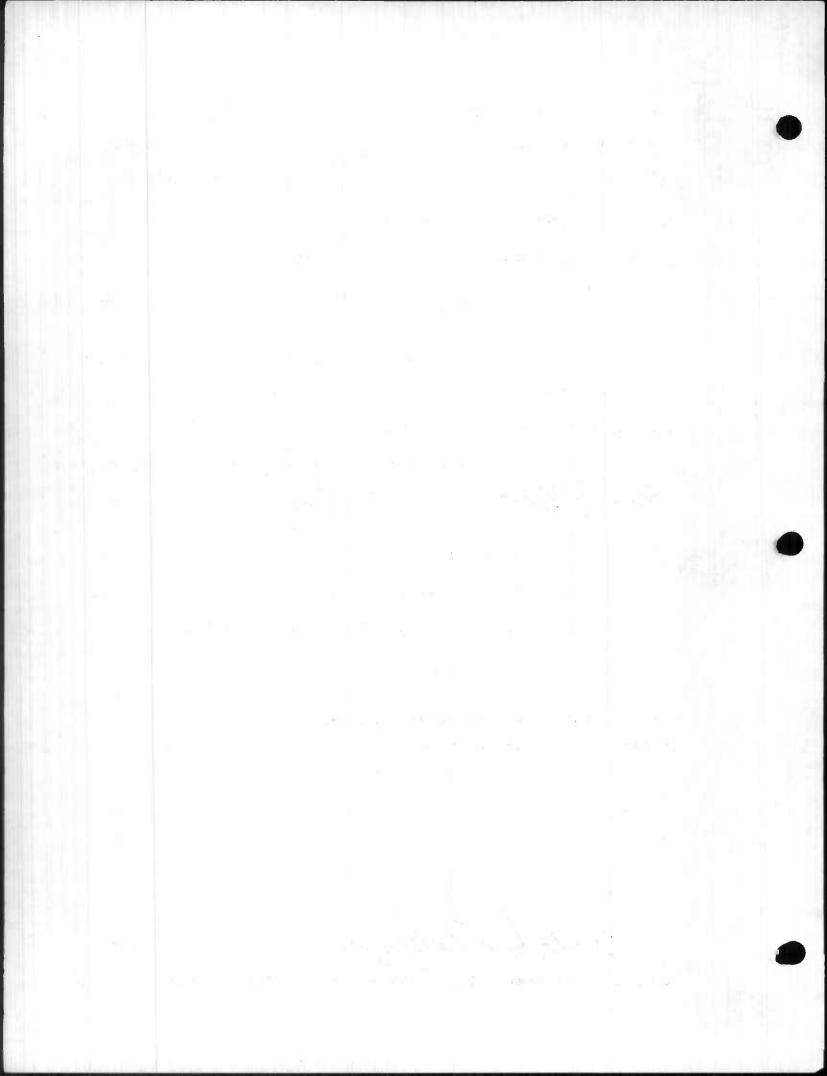
Completed

31. Dete filed (Month, Dey, Yeer) SEP 2 8 2000

Donald R. Richter, M.D.

32. Registrar's Signeture

1533 Memorial Drive Oakland, MD 21550



State of Maryland / Department of Health and Mental Hygiene

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	Decedent's Name (First, Middle,	Last)		Certific	ate of	Death	2. Date of Deal			3. Tima of Death
Physician							Month	Day	Year	5:10PM
/Medical	Rayfeld  4a Fecility Name (If not Institution,	Harold give street and number	Gt.	enther	1	4b. City, Town, or L	Septembocation of Deeth	er 24,	2000 of Death	D: LUPM
Examiner	40522 Port Pl					Leonardto			Mary'	c
Funeral			ge (In yrs. lest.		nder 1 Yeer	If Under 24 Hrs.	8. Date of Birth (Month, Day)			e (State or Foreign
Director	193-12-6060 Usual Residence of Decedent	1⊠ M 2□ F	30	Yrs. Mon	ths Days	Hours Min.	February			
No.	10a. State 10b. County		10c. City, To	own or Location			130		10d.	Inside City Limits
or the short be notified at Director		Mary's	Leo	nardtow	n					1 ☐ Yes 2 ☒ No
or the county	10e. Street and Number			10f.	Zip Code		1	0g. Citizen of \	What Country	?
ral ral	40522 Port Plac					)650		US		
al, or items Examiner in by Fune	11. Marital Status  1 □ Never Merried 2 □ Marrie  3 ☑ Widowed 4 □ Divorced	12. Was Deceden Armed Forces d 17 Yes 2 If Yes, Give Year or Dates	? INo		ecedent of H specify Cube s 2 2 No	lispanic Orlgin? (Sp en, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		ea - American ck, White, etc /: Whi	
ated sta	15. Decedent's (Specify only highest	Education	16	6a. Decedent's I	Jsual Occup	eation during most of world)	kina	16b. Kind of B	usiness/Indus	stry
Complet	Elementary/Secondary (0-12) 12th Grade	College (1-4or	5+)			eloper	Na ing	Home (	Constru	action
	17. Fether's Name (First, Middle, L	ast)			u beve	_	ne (First, Middle, I			2002011
o Be	William	Guen	ther			Mary	Evel	vn	Campbe	-11
-	19a. Informant's Name/Relationshi			9b. Meliing Add	ress (Street	and Number or Ru		4	1	
er tra	Daniel J. Guent	her (Son)	4	1014 Br	eton V	Jiew Driv	e, Leona	rdtown	, Mary	Land 20650
	20a. Method of Disposition		ceme	of Disposition	(Neme of or other plea	ca)	Date	20c. Location	City or Town	, State
0 60	1 ☑ Buriel 2 ☐ Cremetion 3 4 ☐ Donation 5 ☐ Other (Spe		Char:	les Memo	orial	Gardens !	9/28/2000	Leonar	dtown,	Maryland
ettending physician end 3 0 0 0 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Immediate Ceuse (Final disease or condition resulting in death)  Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. lar	Due to (or es Due to (or as	a consequence  yo Card  a consequence  outlet	or): al m or): f drs	ease	n		d	lays
eteched for use a	Part II. Other eignificant condition	s contributing to death	but not resulting	g in the underlyi	ng cause giv	ven in Part I.	23b. Dld to	obacco uee co	ntribute to th	ne cause of death?
Physic							1 🗆 Y	es 2 No	3 Probal	bly 48.Unknown
Completed by P							24a. Was a perfor		evaile	autopsy findings able prior to eletion of cause ath?
Com							1 D Y	es 2KNo	101	res 2□ No
Be C	25. Was case referred to medical					26. Place of Dea	ith (Check only or	10)		
- O	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpa	ient 2 ER/	Outpatient 3	DOA OIL	ner: 4 Nursing H	ome 5 BResid	ence 6 DOth	ner (Specify)	
Certification:	27. Manner of Death  1. Natural 5 Pending 2 Accident Investigat	ition	ey Year) 281	b. Time of Injury M	28c. Injur Wor 1 🗆	yat rk? Yes 2 □ No	28d. Describe h			
d in by	3 Suicide 6 Could not determine	led 200. Placa of I	njury - At home, atc. (Specify)	, farm, street, fa	ctory, office		28f. Location (S City or Tow	treet and Numi n, Stete)	ber or Rurel F	Route Number,
completely filled in by		Physician: To the bes xaminer: On the basis and manner:	of examination							
Me Me	29b. Signetyre and title of certifier		E 150		29c. Licens	se number	2	9d. Dete signe	ed (Month, Da	y, Year)
		no	no	11	DYZ	197		9-26-	00	
	1				- 10					
within 2 To the comple	30. Numerand address of person was Jeffrey Brown,					Maryland	20650			

DHMH 16 Rev 6/95

3. Time of Death

10:06PM

2. Date of Death Month

Day

SEPTEMBER 11, 2000

Examiner	4e Facility Neme (If			umber)				4b. City, To	wn, or Lo	ocation of Dea	ith 4c. Count	y of Deeth	
		y's Hosp						Leona				Mary's	
Funeral Director	5. Social Security Nu 218-16-33	37	ex □M 2■F	7. Age (In yrs. 77	last birthday, Yrs.	If Unde Months	r 1 Year Days	If Under:	Min.	8. Date of B (Month, D June 1		9. Birthplace Country) Maryla	(State or Foreign
show id.at	Usual Residence of 10a. State	Decedent 10b. County		10c Ci	ty, Town or L	ncation						104	Inside City Limits
tor	Maryland	St. Mar	v's		Lexing		ark						1 ☐ Yes 2 ■ No
be notified at Director	10e. Street and Num					10f. Zip					10g. Citizen of	What Country's	
	46738 Wi	llows Fo	rest L	ane			20	653			United	States	
by Funer	11. Marital Status  1 Never Marrie  3 Widowed		Armed F	2 No	l,S. 13.	Was Dece If Yes, spe			gin? (Sp , Puerto	ecify Yes or N Rican, etc.)		ce - American lock, White, etc.	
Completed	(Special	15. Decedent's Ed fy only highest gra ndary (0-12)	de completed	) (1-4or 5+)	16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	al Occup ork done se retire	pation during most d)	t of work	ing	16b. Kind of B	usiness/Indust	ту
00	11				Hous	sewife	9				N/A		
Be	17. Father's Neme (/							18. Mothe	r's Name	e (First, Middl	e, Maiden Sumar	me)	
2	Caleb Wh									Eve Hai			
	19a. Informant's Na	me/Retationship (7	Type, Print)		19b. Mail	ng Addres	s (Street	and Numbe	or Run	al Route Num	ber, City or Town	, State, Zip Co	de)
	Beverly 20a. Method of Dispo	J. Gough	/ Dau		P.O.			Park	Ha1	1, Mary	yland 20	667 - City or Town,	
ance ance		J. T. T. Rizzo	see)	St.	22	2. Name a	Holl	vwood	B Roa	rinsfie d. Leon	Scotlan eld Fune nardtown errest,	ral Hom	
	fmmediate Cause (F disease or condition resulting in death)	inal I	A	Support	E P	fueros of	2	>		145	Mil	1	8 hzs.
Physician/Medical Examiner	Sequentially list con if eny, leading to imr cause. Enter Under Cause (Disease or it that initiated events resulting in death) Li		b	18	To as a ponso To y as a consec Mic	me	Ma	J Via 1Fe	ly	uis uro		y	rs.
hed for use as the burial-transitysician/Medical Examir	Part II. Other signific	ant conditions of	ontributing to	seath but not res	ulting in the u	inderlying o	cause gi	ven in Part I.		23b. Did	f tobacco use co	ontribute to the	cause of death?
- F		Zyste	mic	Lug	456	149	the	male	He	1 10	Yes 250 No	3 Probabi	y 4 Unknown
s been s 2 should pleted		1			- 6	1				24a. Wa	s an autopsy formed?	24b. Were available ormple of dea	sutopsy findings ble prior to ation of cause th?
certificate ha										10	Yes 287No	1 UY	ns 2□ No
director, o Be	25. Was case referre examiner?	United the season to the							of Deat	h (Check only	one)		
E 0	1 ☐ Yes 2(0) N	No.	Hospital: 1 III	Pincationt 20	FR/Dutnetie	et SELDE	DA OE	NOT AFT NU	mino Ho	me 5 Tiller	idence 6 Flore	her (Specify)	

Gough

see contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 255No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4□ Nursing Home 5□ Residence 6 □Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the condition of the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the condition of the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and due to the c ninetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Dey, Year)

Division of Vital

NAME:

State Registrar

Medical Certification: To

To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifical

31. Date filed (Month, Day, Year) SEP 14 2000

30. Name and address of person who completed

DR. JAMES JARBOE

5 Pending investigation

6 Could not be determined

time

29b. Signature and title of certifier

1□Yes 2間No

27. Manner of Death

1@Natural

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

1. Decedent's Name (First, Middle, Last)

Lena

**Physician** 

/Medical

HOLLYWOOD, MD. 20636 32 Registrar's Signature

1. Pinpatient 2□ ER/Outpatient 3□ DOA

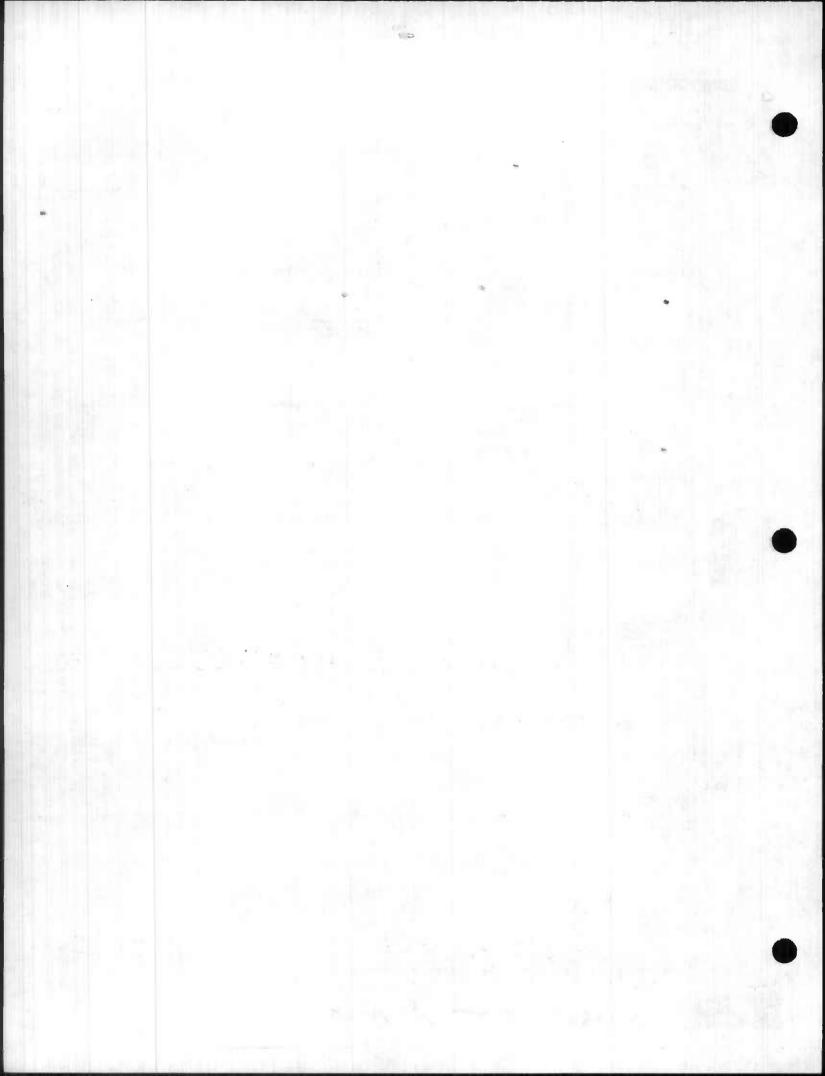
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

of death (ftern 23a) (Type, Print)

28b. Time of

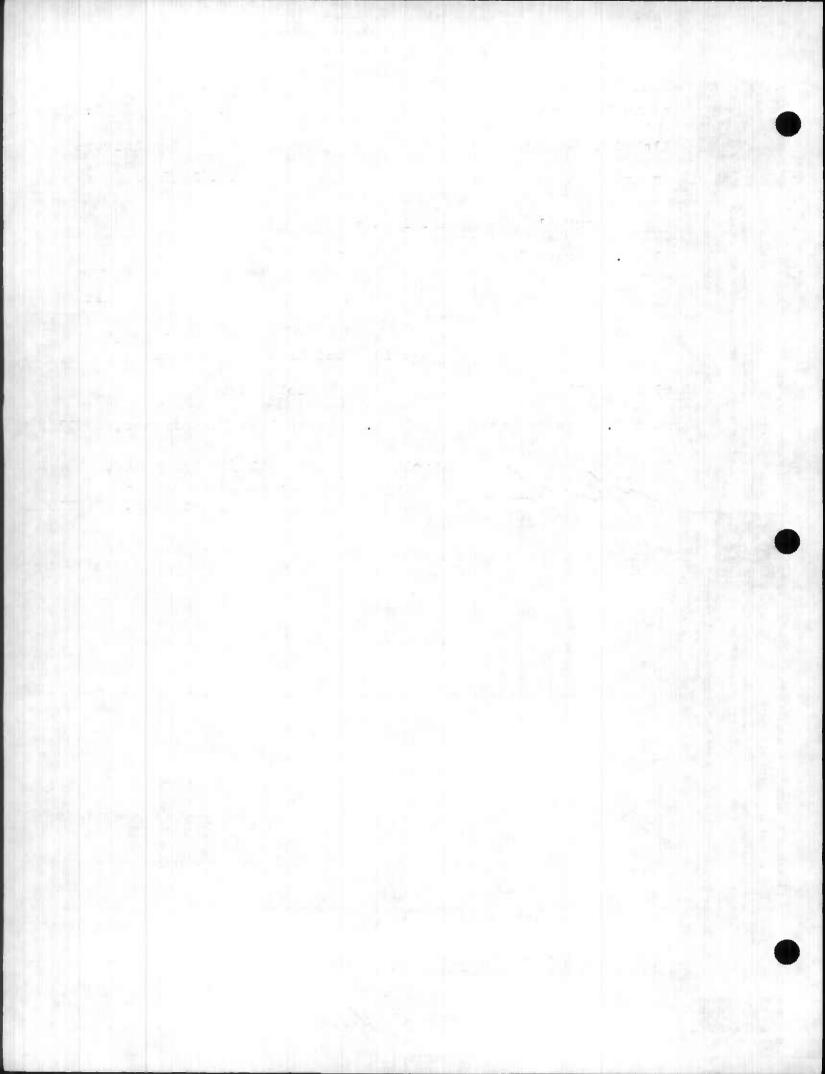
28c. Injury at Work?

1□ Yes 2□No



•	0	0	press.	0	0	
	J	6	J	U	8	

						16111000	10 01	Death			Reg. No.		
	1. Decedent'a N	Name (First, Middle, Li	ast)					-		2. Data of De Month	eath Day	Yaar	3. Time of Dea
ician dical	Jack:	ie Lee Ho	we						5	Sept	30	2000	1:05am
iner	4a Facility Nam	ne (If not institution, gi	ve street and numi	ber)		4111		4b. City, To	wn, or Loc	cation of Deat	h 4c. Cour	nty of Death	
	Gilcl 5. Social Securi		Sex 7	. Age (In yrs. I	last birthday)	tf Under	er 1 Year Days	T O W	ZSON 24 Hrs.	8. Data of Bii (Month, Da	rth	9. Birth	more placa (State or Fo
Н	216-66 Usual Rasidend	5-4913	1□M 200≭	47	Yrs.	HOTAITS	Duys	110010	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		13 19		MD
	10a. State	10b. County		10c. City	y, Town or Le	ocation	76-						10d. Inside City Li
Director	MD	Carro	11	We	estmi	nste	r						1 N Yes 2 □
-	10e. Street and	Number				10f. Z	ip Code		-		10g. Citizen o	of Whet Cou	intry?
	301 8	St. Andre	ews Lane	9			211	58			U	SA	
by Funeral		us  Married 25 Married  ed 4 Divorced	12. Was Deced Armed Ford 1  Yes 2 If Yes, Give Year or Dat	ces?			9-1-7	Hispanic Ori an, Mexicar Specify:		cify Yas or No Rican, etc.)	o- 14. R B	ace - Ameri lack, Whita, cify: W]	
		15. Decedent's E	Education		16a. Dece	edent's Us	ual Occup	pation			16b. Kind of	Business/In	ndustry
		Specify only highest gr Secondary (0-12)	ada complated) College (1-4	4or 5+)	(Give	DO NOT	use retire	during mos d)	t of workir	ng	Publi	c Scl	hool
			5		Med	dia	Spec	ciali	st		Syste	m	
	17. Father's Na	me (First, Middle, Las	t)	to the last				18. Mothe	er's Name	(First, Middle	, Maiden Sum	eme)	
10 Be	Garlar	nd Philli	.ps		JIA			Vio	let	Warre	en		
	19e. Informent	's Name/Retetionship	(Type, Print)		19b. Maili	ing Addre	ss (Stree	end Numb	er or Rure	Route Numb	per, City or Tow	m, State, Zij	ip Code)
	Ernest	t J. Howe	Husbar	nd	301	St.	And	drews	Lar	ne Wes	stmins	ter.	MD2115
	23a. Part1. En shock, or	iter the disaasa, or cof heert feilure. List only			h. Do not en	12 W	ash ode of dyi	ingto	n Ro	l West	nd Cha tminst arrest,		Approximate Interval Betwe Onsat and Dec
sian/Medical Examiner	disease or con resulting in dea Sequentially lis if any, leading cause. Enter Cause (Diseas that initiated ev resulting in dea	ath) st conditions, to immediate Inderlying a or injury vents	a. Ke	Due to (o	C C.  r as a conse  r as a conse	equence of	(): ():						years
5	disease or con resulting in dea Sequentially lis if any, leading cause. Enter Cause (Diseas that initiated ev resulting in dea	ath) st conditions, to immediate Inderlying a or injury vents	a	Due to (o	r as a conse	equence of	(): ():	ven in Part	l.		I tobecco use		
	disease or con resulting in deal service. Sequentially list if any, leading cause. Enter Cause (Diseas that initiated ever resulting in deal	st conditions, to immediate Inderlying a or injury rents ath) Last	a	Due to (o	r as a conse	equence of	(): ():	ven in Part	l.	1 [ 24a. Wa:		24b. W	Obably 4 Uni
Completed by Physician/M	disease or con resulting in deal service. Sequentially list if any, leading cause. Enter Cause (Diseas that initiated ever resulting in deal	st conditions, to immediate Inderlying a or injury rents ath) Last	a	Due to (o	r as a conse	equence of	(): ():	ven in Part	i.	1 C 24a. Was perf	Yes 2 No	24b. W	Vere autopsy find vailable prior to ompletion of caus death?
Be Completed by Physician/M	disease or con resulting in dea Sequentially lis if any, leading cause. Enter Cause (Diseas that initiated ev resulting in dea	st conditions, to immediate Inderlying a or injury rents ath) Last	a. b	Due to (o	r as a conse	equence of	f): i): ):	26. Pleci		1 C 24a. Was perf	s an autopsy ormed?	24b. W	Vere autopsy find vailable prior to ompletion of cause of death?
to be completed by ringsicialitim	Sequentially list any, leading cause. Enter Cause (Diseas that initiated exresulting in dealers.)  Part tl. Other all 25. Was case rexaminer?  27. Menner of I Nener of I American Accide	st conditions, to immediate Inderlying a or injury rents ath) Last	d  contributing to dea  Hospitat: 1 □ In  28e. Dete of (Month)	Due to (or  Due to (or  Dua to (or  eth but not rest	r as a conse	equence of	OOA OI 28c. Inju	26. Pleci her: 4 □ Ni	e of Death ursing Hor	24a. Wa: peri	s an autopsy ormed?  Yes 2000 one)	24b. W a' c c c c c c c c c c c c c c c c c c	Vere autopsy find vailable prior to ompletion of causified eath?  Yas 2 No
To Be Completed by Physician/M	Sequentially list if any, leading cause. Enter Cause (Diseas that initiated evresulting in dealers). Part tl. Other sl. 25. Was case reaminer? 1 Yes 27. Menner of I Neatural	ist conditions, to immediate Juderlying a or injury rents atth) Last	d	Due to (or  Due to (or  Dua to (or  eth but not rest	r as a conservation of a conse	equence of	ooo Ot Ot 28c. Inju We 1 [	26. Plece her: 4   Ne iny at ork? ] Yes 2	e of Death ursing Hor	24a. Was period (Check only me 5 Res 28d. Describe	s an autopsy ormed?  Yes 2000 one)  idence 6 one	24b. Was a construction of the coursed	Obably 4 Unit Vere autopsy find vailable prior to completion of caus of death?  Yas 2 No
To Be Completed by Physician/M	Sequentially lis if any, leading cause. Enter Cause (Diseas that initiated evresulting in dealers and the cause in the cau	st conditions, to immediate Judenlying a or injury rents atth) Last  referred to medical 22 1000  Death   5   Pending investigetic   6   Could not lidde   Could not lidde   1   2   2   2   3   3   4   4   4   4   4   4   4   4	d	Due to (or  Due to	ER/Outpatie 28b. Time of Injury wiedge, deal	equence of	DOA Ot 28c. Inju We 1 Cory, office	26. Plece her: 4□ No ry at rk? ] Yes 2□	e of Death ursing Hor I No	24a. Wa: perl	s an autopsy ormed?  Yes 2000 one) idence 6 one how injury occurred and Nuwm, State)	24b. Was a composition of the coursed	Vere autopsy find vailable prior to completion of caus of death?  Yas 2 No
	Sequentially lis if any, leading cause. Enter Cause (Diseas that initiated exresulting in dealers).  Part tl. Other all Part tl	st conditions, to immediate Judenlying a or injury rents atth) Last  referred to medical 22 1000  Death   5   Pending investigetic   6   Could not lidde   Could not lidde   1   2   2   2   3   3   4   4   4   4   4   4   4   4	d	Due to (or  Due to	ER/Outpatie 28b. Time of Injury wiedge, deal	equence of	on, in my	26. Pleccher: 4 North No	e of Death ursing Hor	24a. Wa: perf  1 □  2(Check only me 5 □ Res 28d. Describe  28f. Location City or To	s an autopsy ormed?  Yes 2000 one) idence 6 one how injury occurred and Nuwm, State)	24b. Was a construction of the coursed	if death?  Yas 2 No  rel Route Number,  stated. to the cause(s)
Be Completed by Physician/M	disease or con resulting in deal side of the control of the contro	st conditions, to immediate Juderlying a or injury cents ath) Last  Independent conditions  referred to medical  2 No  Death  5 Pending investigetic a feet Could not to determine of the conditions  1 Contifying P	d	Due to (or  Due to	ER/Outpatie 28b. Time of Injury whedge, dealtion and/or in	equence of	on, in my	26. Pleccher: 4 □ Niry at rk?  Yes 2 □	e of Death ursing Hor	24a. Wa: perf	s an autopsy ormed?  Yes 2000 one)  idence 6 one injury occ (Street and Nuwn, State)  e cause(s) and, date and plec	24b. Was a composition of the coursed	Vere autopsy findivailable prior to completion of caus of death?  Yes 2 No  Well Route Number stated. to the cause(s)
edical Certification: To Be Completed by Physician/M	disease or con resulting in deal side of the control of the contro	st conditions, to immediate Inderlying a or injury cents ath) Last  Inderlying a beginning to the conditions of the cond	d	Due to (or  Due to	ER/Outpatie 28b. Time of Injury whedge, dealtion and/or in	equence of equence equenc	OOA Ot Ot Oor, office on, in my	26. Pleccher: 4 North No	e of Death ursing Hor	24a. Wa: perf	s an autopsy ormed?  Yes 2DNo one)  idence 6 No how injury occurred. (Street and Numer, State)  e cause(s) and d, date and plectory.	24b. Was a composition of the coursed	Vere autopsy find vailable prior to completion of cause of death?  Yes 2 No villy) Hos p to rel Route Number stated. to the cause(s)



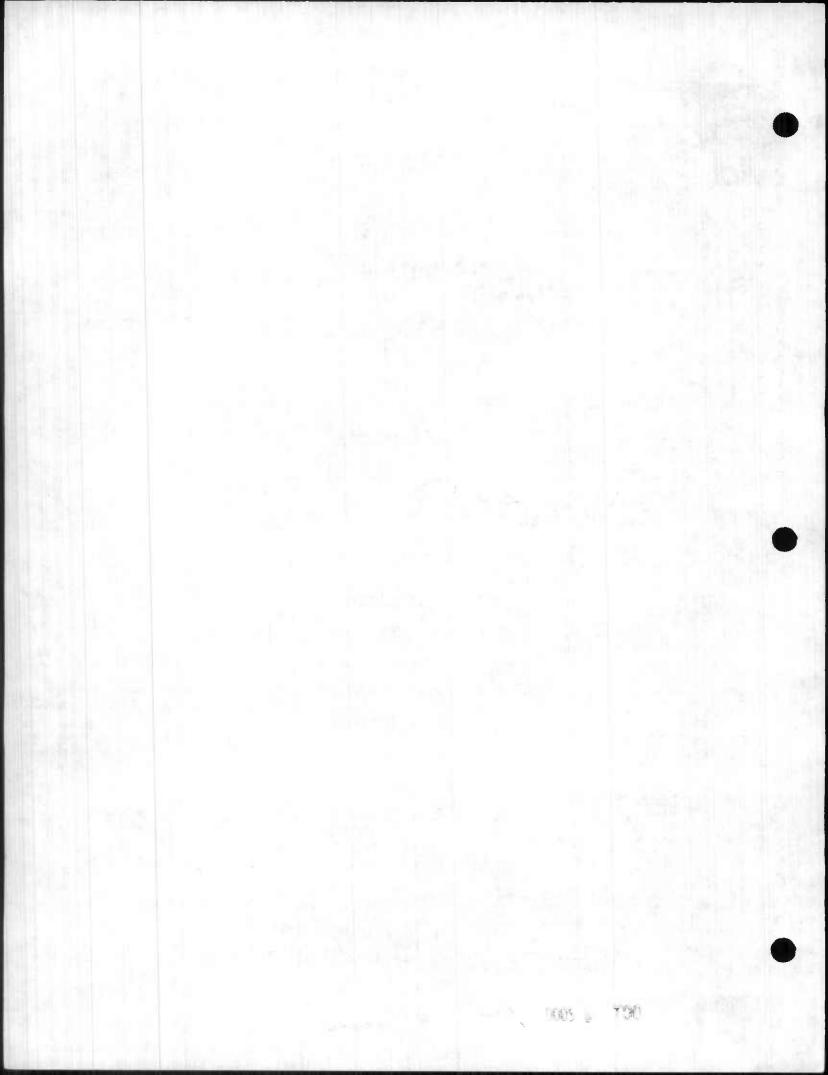
State of Maryland / Department of Health and Mental Hygiene

32589 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day **Physician** Ruth Ann Heinefield October 3, 2000 0100 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner Kent & Queen Anne's Hospital Chestertown 7. Age (In yrs. lest birthdey) If Under 1 Yeer 5. Social Security Number 8. Dete of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) **Funeral** Min. 1 M 200 Months Deys Hours 65 Yrs. 217-80-8823 Director August 9, 1935 Chestertwon, Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Counts \*natural", or items 23a or 28a-f show 1 ☐ Yes 2X No Director Maryland Kent Rock Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5228 Skinners Neck Road 21661 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Merital Status Bleck, White, etc. 72 hours after 1 ☐ Never Married 21 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 ht. Depertment of Health and Mentel hygiene. The propriet if item 27 is marked other than "natur. any Injury or other treumstic event, the Medical once." Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cotlege (1-4or 5+) Homemaker Own home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Silver Joseph Gsell, Sr. Alice Morris 19e. Informent's Name/Relationship (Type, Print) 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Herman Heinefield 5228 Skinners Neck Road, Rock Hall, Maryland 21661 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removet from State 4 ☐ Donetion 5 ☐ Other (Specify) Wesley Chapel Cemetery 10/5/2000 Rock Hall, Maryland 21. Signeture of Funeral Service Licenses 22. Neme end Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620, speed on each line. 23a. Pert1. Enter the disease, or complication shock, or heart feilure. List only one card Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ACURE 6.1. Hemanukla Examiner Due to (or es e consequence of): Physician/Medical Examiner sician end buriel-transit GUNGEUR UMILLA Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) 68760 Nitrushous Animi DS

Due to (or es e consequence of): 20 7cm -ERTY'S SYMPHEMES Box USB 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 20 No 3 Probably 4 Unknown of Vital Records. þ 24b. Were eutopsy findings aveilable prior to 24e. Wes en eutopsy performed? Completed completion of cause of deeth? 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) examiner? Hospitel: 1 Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Menner of Death 28d. Describe how injury occurred 28c. Injury et Work? After Division Attending 5 Pending investigation 1 Netural death. 1 Yes 2 No 2 Accident Director: / 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Ptece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) aftar a 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated. edical 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certified 1-0013824 16.34 46 30. Name and address of pason who completed cause of death (Item 23a) (Type, Print) 15 John C. Seymour, 122 Speer Road, Chestertown, Maryland 21620 32/Registrar's Signeture 31. Date filed (Month, Day, Year) State 4 2000 Registrar

**DHMH 16 Rev 6/95** 



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death HERRING SEPT Year **Physician** MAUDE 33 2:15 Pm 2000 /Medical 4e Facility Name (If not institution, give street end number)
GOODWILL MENNENITE 4b. City, Town, or Location of Deeth 4c. County of Death Examiner GRANTSVILLE GARRETT GOODWILL Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Yeer) 01 - 18 - 1904 7. Age (In yrs. lest birthdey) **Funeral** 1 M 2 F Months Days 170-36-4768 96 Yrs. Director Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ? is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinar must be notified as MO 1 Yes 2 No GARRETT GRANTSVILLE Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? DORSEY HOTEL 21536 US.A permit. Peges 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiane. Important: If Item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must and DDCs. Funeral 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE Baltimore, Maryland 21215-0020 by 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry PUBLIC SCHEOUS Elementery/Secondery (0-12) College (1-4or 5+) 1 EACHER SCHOCK 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) HERRING ALBERT MARY SIEHL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4786 CUMBERLAMD HWY, MEYERS DAUE, PA 15552 19a. Informant's Name/Relationship (Type, Print) w. BITTNER DARRELL 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 9-25-00 MEYERSDALE, PA 12 Burial 2 Cremation 3 Removal from State UNION CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility W. R. PRICE FUNERAL HOME INC 21. Signature of Funeral Service Licensee CC 0376 MEYERSDACE PA 15552 Mulliam X MAIN ST 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final trolle weeks disease or condition resulting in deeth) Examiner Due to (or as e consequence of) Examiner the death certificate be executed physician end the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of) 88 USB for 23b. Did tobacco use contribute to the cause of death? ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown ldimin Ti A þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes an autopsy performed? Completed irector, page 2 s 1 Yes 2 No ... or Vital
...sepital or Attending Physician: The
hin 24 hours after deeth.
he Funeral Director After this neverty filled in by the 1 Vas 2 No 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how Injury occurred 27. Menner of Death 28b. Time of Certification: 1 Natural 5 Pending Investigation 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es stated. edical To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date end pleca, and due to the cause(s) (Check only one) 29d Date signed (Month, Dey, Year) 29b. Signeture end title of certifier (3) mi 30. Name and address of person who cometed cause of deeth (Item 23e) (Type, Print)

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32. Registrar's Signature

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21536

State Registrar

Moune HERRING The comment there were the comment of the state of 39 X Tarv & 90 F084-31-12 CAN CHARLE CHARLES CAN get auger thron to 78817 De Hora TBACHER ALBERT HEARING MARS SIERE BREEFER OUT BROWNING 4750 BURGALIES MAN, HERMERSONES PA 1503 HE Charles Company with a premission PA Leddlem of the coasts so now it makes process of usual

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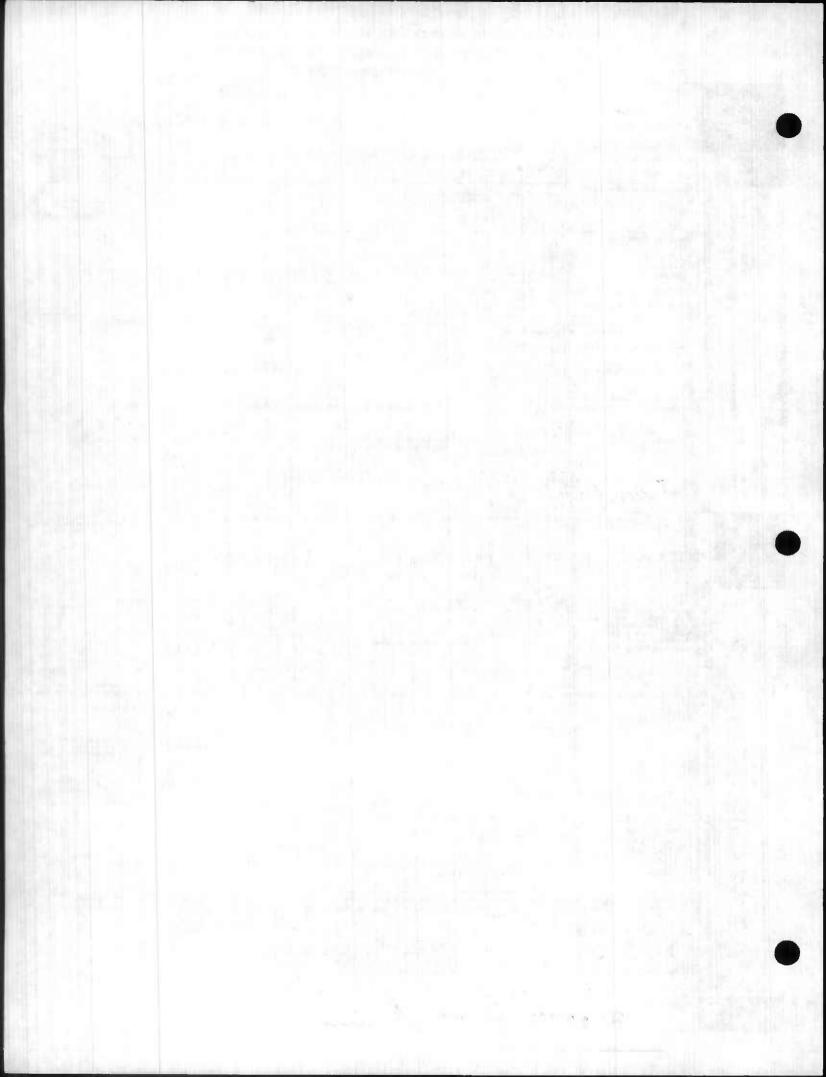
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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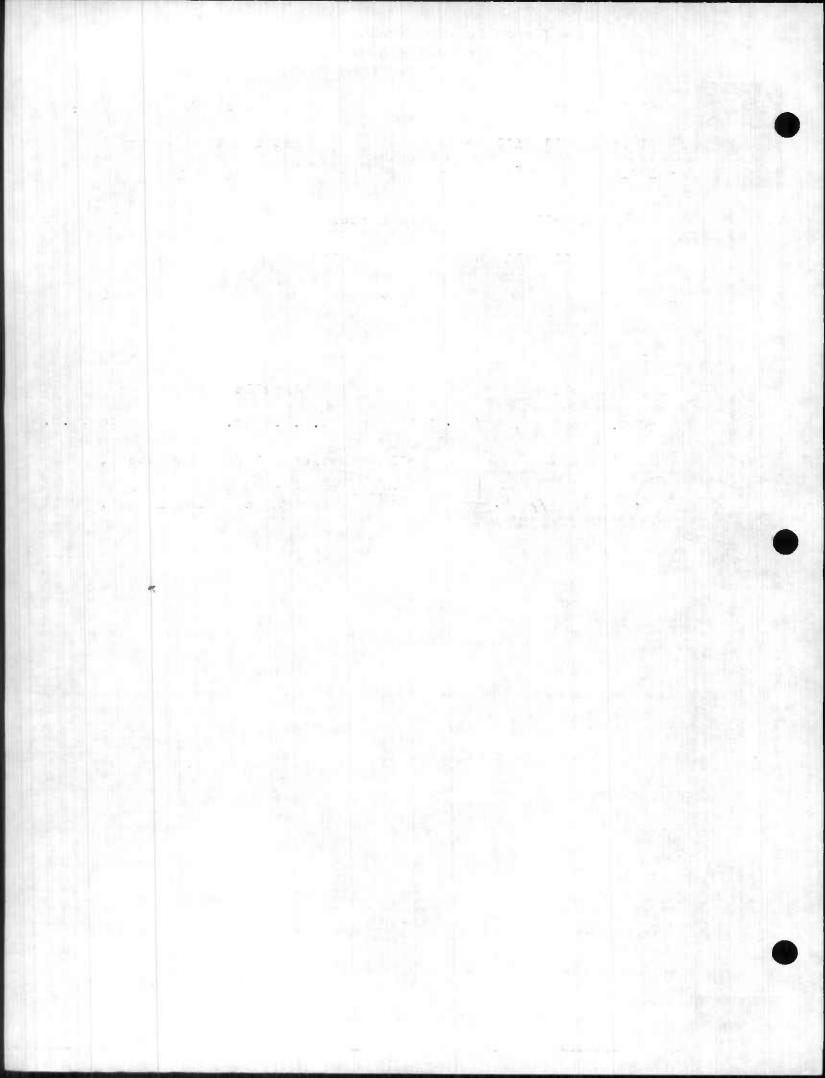
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							Cer	lilicale of	Deali			Reg. No.		
	_	1. Decedent's Name (First, Middle	e, Las	it)							2. Date of De			3. Time of Death
	_	Gertrude		Surra	++		H	oskins			Month	ber 15,	Year 2000	7.20
		4a Facility Nama (If not institution	n ohen				11/	JSKINS	4h City To	own or la	ocation of Death	-	y of Death	7:30 p.m.
) Examiner	r	ea Facility Nama (III not institution	n, give	street and no	umber)				4D. Oity, 10	JWIT, OF L	ocation of boats			
	ш	36676 Wilson	Dr	rive						shwo			Mary	's
Funeral		5. Sociat Sacurity Number	6. Se		7. Age (	In yrs. last b	irthday)	If Undar 1 Year Months Days		24 Hrs. Min.	8. Data of Bir (Month, Da	th v Year)	9. Birth	placa (State or Foreign
yaldien: The law requires that the death certificate be executed be executed be executed by the attending physician and be executed by the attending physician and be detected for use as the burial-transit and important; if them 27 is marked other than "natural", or thems 23a or 28-4 show and important; if them 27 is marked other than "natural", or thems 23a or 28-4 show and important; if them 27 is marked other than "natural", or thems 23a or 28-4 show and in a part of inspector, page 2 should be detected for use as the burial-transit and marked other than "natural", or thems 23a or 28-4 show and in a part of inspector and in a part of inspector and inspector are all processes.  To Be Completed by Physician/Medical Examiner  To Be Completed by Funeral Director		577-22-2322	1[	□ M 2 F	8	7	Yrs.	Month's Days	nouis	IVINI.	April	4, 1913	Sout	h Carolina
	1	Usual Rasidence of Decedent												
E S III	Department of health state of the result of the resu	10a. Stata 10b. County			1	Oc. City, Tov	wn or Loc	cation						10d. Inside City Limits
Aary Sh	5						1							1 ☐ Yes 2 ■ No
2 2 3	2	Maryland St.	Mar	y's		1	Bush	*	-2					
5 6 6	1	10e. Street and Number						10f. Zip Coda				10g. Citizen of		
h w 18		36676 Wilson	Dr	cive				2061	.8			United	Stat	es
dea me me	D	11. Marital Status		12. Was Dec	cedení Eva	ar in U,S.	13. V	Vas Decedent of Yes, specify Cul	Hispanic O	rigin? (Sp	ecify Yas or No	- 14. Ra	ca - Americ	
	5	1 Nevar Marriad 2 Mar	ried	Armed F 1 ☐ Yas	2 I No						rican, atc.)	BIE	ack, Whita,	atc.
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		23a. Part1. Entar tha diseasa, or shock, or haart failura. List	comp only o	otications that	caused the	a daath. Do	not anta	er the mode of dy	ring, such as	s cardiac	or respiratory a	rrast,		Approximata Intarval Batween
Physician													1	Onset and Death
/Medical		Immediata Causa (Final			M		1 -	ial 9	nota	770	tion			one
Examiner	-	disease or condition resulting in deeth)		8.					1000		0.011		-	mony
ر المسلمات	5				Du	a to (or as a	conseq	uance or):					1	
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ourie T		if any, laading to immadiata cause. Enter Underlying Causa (Disaase or injury												
ate the the the the the the the the the t	2	that initiated avants rasulting in death) Last		0.	Du	a fo (or as a	consequ	uence of):						
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the d	2	Part II. Other significant condition	ons co	intributing to d	death but r	not resulting	in tha ur	nderlying cause g	iven in Part	1.	23b. Did	tobacco usa c	ontribute t	to the cause of death?
d by letace											10	Yes 2 No	3 Pro	bably 4 Unknow
b se th	2												1	
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S a set	<u> </u>										point	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	CC	omplation of cause f death?
has be 200 200 200 200 200 200 200 200 200 20												A .		
E and C	3										10	Yas 214 No	1	☐ Yes 2☐ No
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olife dire		1 Yes 2D No		Hospitel: 1	Inpatient	2 ER/0	utpatien	BOA O	thar: 4 N	lursing He	ome 5 Aasi	idenca 8 🗆 O	her (Speci	ify)
2 E E E		27. Mannar of Death		28a. Deta	of Injury		Tima of	28c. fnj	ury at ork?		28d. Describe	how Injury occu	irred	
To Attending after death. Director: After din by the func	2	1 Netural 5 Pandir			nth, Day Y	ear)	Injury		Yes 2	] No				
the story of the story	2	3 ☐ Suicida 6 ☐ Coutd	not be	28a Plec	a of follow	- At homa 1	farm stra	at, factory, office	4		28f. Location /	Street and Nun	ber or Rui	ral Route Number,
Ital or Attending Purs after death.  el Director: After tiled in by the funer.  Certification:		4 ☐ Homicide datam	IIIIeu		ding, etc. (						City or To	wn, Stete)		
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To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		one)			nner state			_angunon, strilly	Spanion, de	0000	. 50 0. 010 0010,	Late and piece	,	
To the composition of the compos		29b. Signatura and titla of certifie	r					29c. Licar	nsa number			29d. Date sign	ed (Month,	, Day, Year)
F 3 F 0		> Sc Ga	In			M.	D.	7	54:	3 4	1-	9/1	8/0	()
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m.	1	30. Name and addrass of person												
2. 4		Chandra B. Sa	jja	, M.D.	, 240	)35 Th	ree	Notch R	oad, I	Holly	wood, I	Marylan	1 206	36
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Registrar	_	SFP 21	0 21	กกก	Den	war	1	Ann	161					



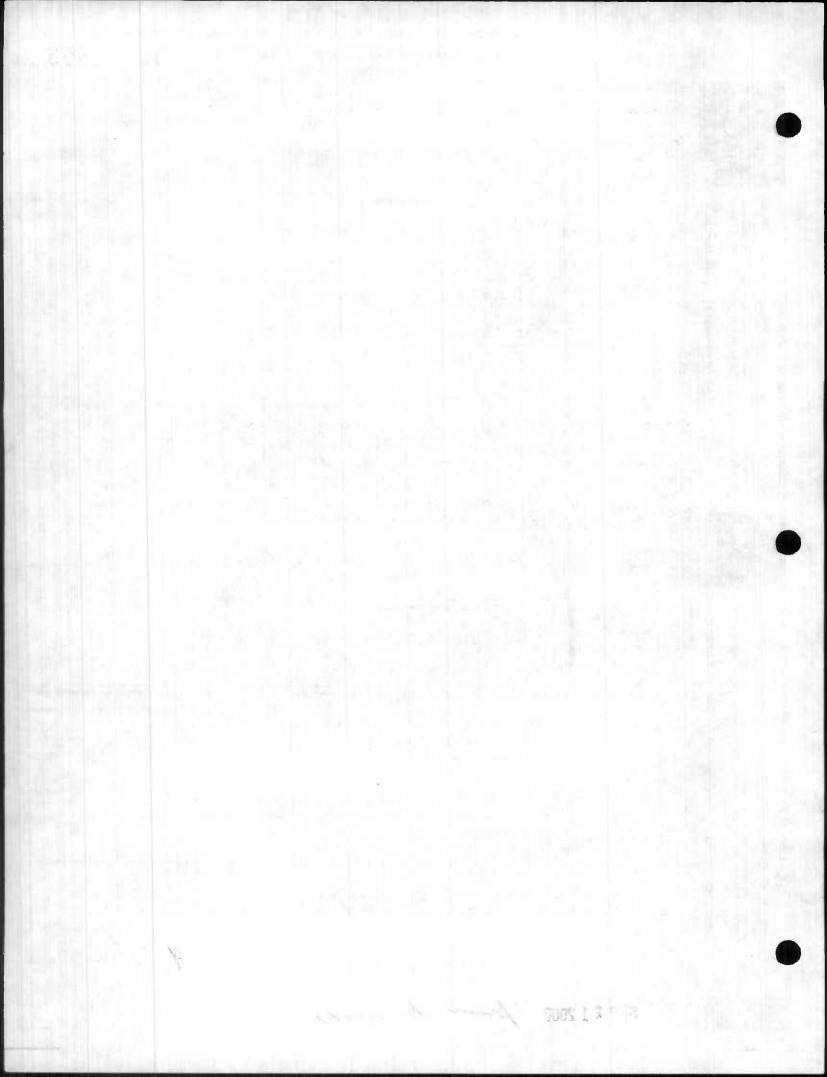
State of Maryland / Department of Health and Mental Hygiene

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	/Medical Examiner	de Caultin blance III and landbitten a	ive street and numb	per)			- 4	lb. City, Town,	or Location of Dea	th 4c. County	of Death	
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_	5				last birthday)	If Under	1 Yeer	If Under 24 I				place (Stete or Foreign intry)
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	Director	Usual Residence of Decedent		1 -	L				1000	2 1920		CA
	B R	10a. Stete 10b. County		10c. Cit	y, Town or Lo	cation						10d. fnslde City Limits
	day	MD Carr	077		Westn	ningt	er					1 ☐ Yes 2 ☐ No
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7	the plant	12			Ho	omema	akeı			Own H	ome	
Maryland	※工事 6	17. Father's Name (First, Middle, Las	st)					18. Mother's	Name (First, Middle	e, Meiden Sumam	e)	
9	dental of contal		ige					Manu	ella Pa	raza		
3	N P P P	19a. Informent's Name/Relationship	(Type, Print)		19b. Meilin	ng Address	(Street	end Number o	r Rural Route Num	ber, City or Town,	State, Z	ip Code)
Ĕ	2000	Edward B. Jenn		R/son	1318	22nd	i St	.N.W.	Ste.10	5 Washi	ngt	on.D.C.
o c	9929	20a. Method of Disposition	11160,	20b. F	Place of Dispo	sition (Nan	ne of		Date			own, State 20037
ō	50 H 0	1 Burial 2 Cremation 3		ate	ametery, cren	natory or o	ther plac					
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	-	23a Party Fritar the disease, or co	mplications that cau	sed the deat	h. Do not ent	er the mod	e ot dyir	g, such as car	diec or respiratory	errest,	1	Approximete Intervat Between
9	Physician	andox, or near tallure. List on	ry one cause on eac	an line.							1	Onset and Death
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	Examiner	disease or condition resulting in death)	a		arias		_ 4 4	cer			1	8 months
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6876U,	Clan Durie	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	С								i	
0	the the	fhet initiated events resulting in death) Last		Due to (o	r as a conseq	uence of):					i	
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	0 0 0	Part if. Other significant conditions	contributing to deat	th but not res	ulting In the u	nderlying c	ause giv	en in Part t.	23b. Die	tobacco use co	ntributa	to the cause of death?
7. O.	t tha by th tach	No	r.						10	Yes 2 No	3 Pr	obably 4 Unknown
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é	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use Completed by Physician/M								24a. Wa	s an autopsy	24b. V	Vere eutopsy findings vailable prior to
2	The law requir cate has been s page 2 should								per	formed?	C	completion of cause
	has be 2									/		
5	C Page							1000	1L	Yes 2 INo	1	☐Yes 2☐No
	ertific setor	25. Was case referred to medicat examiner?	Manadad				0.11		Deeth (Check only	(one)		
or vital Records,	hysk of his of I dire	1 Yes 2 No			ER/Outpatier			4 U NUISII	ng Home 5 ☑ Re			city)
	nerd nergen	27. Manner of Death	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	2	8c. Injui	y at k?	28d. Describe	how injury occur	red	
0	ath. r: Af	2 Accident investiget	ion			М	1 🗆	Yes 2 □ No				
DIVISION	Attende cho	3 Suicide 6 Could not	256. PIECE O	f Injury - At h	ome, farm, str	eet, factory	, office		28f. Location	(Street and Numbown, Stete)	er or Ru	ral Route Number,
5	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.  Medical Certification: To Be Compl	TOTALOGO	bulloing	, etc. (Specif	"				Unj or 1	.,,		
	noun noun y fille	29a. Certifier 1 Certifying I	Physician: To the b	est of my kno	wiedge, deett	occurred	et the tir	ne, dete and p	lece, and due to th	e cause(s) and me	enner as	stated.
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	omplomb	29b. Signeture and fittle of certified		e number		29d. Date signe	d (Month	n, Day, Year)				
	- 5-0	Horn	29b. Signeture and fittle of certified 29b. License num  30. Name and address of person who completed cause of death (Item 23e) (Type, Print)  Howard Jaishtz, M.P. 555 S. Canter St.  31. Dafe filed (Month, Day, Year)  32. Registrer's Signature									T
		7.4.4	~	4.500	00.10	D.1-11				, , ,		
		30. Name and address of person who	o completed cause	of death (Item	n 23e) (Type,	Print)	1-	+ /,	a stain a	ter he	1.	21157
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State of Maryland / Department of Health and Mental Hygiene 00 32593

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19s. Informatis Name Relationship (Type, Print)  19c. Meling Autress (Sines and Number or Prival Rouse Number, Cype or Town, Sine, Ze Code)  23 100 Chestrut Hill Lane, Avenue, Maryland 20609  230. Mendod of Disposition  18 Blural 2 Chemation 3 Blaemoval from State  240. Peace of Disposition (Nema or Judges)  250. Peace of Disposition (Nema or Judges)  250. Peace of Disposition (Nema or Judges)  260. Peace of Disposition (Nema or Judges)  260. Peace of Disposition (Nema or Judges)  27 Signature of advances of Facility.  28 Signature of Accretic Prival Accountment of The Comment of State  28. Pence of Disposition (Nema or Judges)  28. Signature of Accretic Prival Accountment of State  29. P. O. Box 270, Leonardctown, Maryland 20609  29. Pent I. Other individual for the disease or confliction of the disease		17. Father's Name (First, Middle, Last) 18. Mo	other's Name (First, Middle,	Maiden Sumeme)
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20. Nethod of Disposition  21. Signatury 12 Contracts and Surface Control State  22. Signatury 15 Funet as Surface Control Control State  23. Signatury 15 Funet as Surface Control Control State  24. Signatury 15 Funet States Surface Control Control State  25. Signatury 15 Funet States Surface Control Control State  25. Signatury 15 Funet States Surface Control Control State  25. Signatury 15 Funet States Surface Control Control State  25. Signatury 15 Funet States Surface States States Surface States States Surface States	DE S	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street end Nur	imber or Rural Route Number	er, City or Town, State, Zip Code)
Secure   S	27.1	Harvey I. Bailey (Friend) 23100 Chestnut H	ill Lane, Ave	nue, Maryland 20609
Several Feart Catholic Cemetery 9/22/2000   Bushwood, Maryland   All Deales   Several Feart Catholic Cemetery 9/22/2000   Bushwood, Maryland   Several Feart Catholic Cemetery 9/22/2000   Bushwood, Maryland   22 Ngnature Funeral Formation   P.A.   P.D. Box 270, Leonardtown, Maryland 20650   P.D. Leonardtown, Maryland 206	of the state		Dete	20c. Location - City or Town, State
22. Signaturis of Funeral Service Licensee  22. Signaturis of Funeral Home, P.A.  P.O. Box 270, Leonardtown, Maryland 20650  23a. Part I. Effect the disease, for complicitations for caused the delay Do not enter the mode of giving, such as cardiac or respiratory errest.  23a. Part I. Effect the disease is considered that the caused the delay Do not enter the mode of giving, such as cardiac or respiratory errest.  25a. Part I. Effect that disease is considered that the caused the delay Do not enter the mode of giving, such as cardiac or respiratory errest.  25a. Part I. Effect that disease is considered to mode the caused of soft and Doest or cardiac an	A HE III	1 EU Burial 2 U Cremation 3 U Hemoval from State	etery 9/22/2000	Rushwood Maryland
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23a Part   Enter the disease of perceptical sign and past and post shock, or hear failure. Its orly one cause on each line.   Approximate and Death Redical annihier part of the part of the past of	on a go			
Indication of the part of the	2012/12/21			
Immediate Cause (Final disease or conditions as a consequence of):		shock, or heart failure. Vist only one ceuse on each line.	res cardiac or respiratory er	Interval Between
disease or condition setuling in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Sequentially ist conditions:  The property of the	nysician		011-	Oliset allo Deat
Due to (or as a consequence of):    Due to (or as a consequence of):		disease or condition	s defait	tros
Cause (Disease or injury that initiated wonts resulting in death) Lest    Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.   Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.   Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.   Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.   Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.   Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.   Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.   Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.   Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.   Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.   Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.   Part II. Other algnificant conditions contribution to the cause of death of the cause of death of the cause of death of the cause of the cause of death of th	STATE OF THE PARTY		1	
Cause (Disease or injury that initiated wents resulting in death) Lest  Or 19	in ei	<b>a</b> b.	Y	
Cause (Disease or injury that initiated wents resulting in death) Lest  Or 19	and -tran	Sequentially list conditions, if any leading to immediate		
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Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death of the cause of death o	dica dica	that initiated events		
24a. Was an autopsy performed?  24b. Were autopsy finding available prior to completion of cause of death?  1   Yes   2   No	0 0			
24a. Was an autopsy performed?  24b. Were autopsy finding available prior to completion of cause of death?  1   Yes   2   No	r us	UI.		1
24a. Was an autopsy performed?  24b. Were autopsy finding available prior to completion of cause of death?  1   Yes   2   No	Sic Sic	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part II.	art I. 23b. Did	tobacco uss contributa to the cause of de
24a. Was an autopsy performed?  24b. Were autopsy finding available prior to completion of cause of death?  1   Yes   2   No	Phy t	(00)	1	Yea 2 No 3 Probably 4 Unk
25. Wes case referred to medical examiner?	be de	COPD		
25. Wes case referred to medical examiner?    Continue of Death   Check only one   1   Yes   2   No   1   Yes   Xes   X	onid be	to Heart Facture	24a. Was	rmed? available prior to
25. Wes case referred to medical examiner?  1   Yes   2   No.    26. Place of Death (Check only one)  27. Menner of Death   1   Inpatient   2   ER/Outpatient   3   DOA    27. Menner of Death   1   Organical	pie She	Congerier 4 - 1 Jacobs &		completion of cause of death?
25. Wes case referred to medical examiner?  1   Yes   2   No.    26. Place of Death (Check only one)  27. Menner of Death   1   Inpatient   2   ER/Outpatient   3   DOA    27. Menner of Death   1   Organization   1   Organization   2   Organization   3   Suicide   3   Suicide   4   Homicide	e ha age	0	10,	Yes 2000 1 Yes 2000
27. Menner of Death 1 Squard 28a. Dete of Injury M 28b. Time of Injury M 28c. Injury et Work? 1 Yes 2 No 28d. Detection (Specify)  28d. Detection (Street and Number or Rural Route Number, City or Town, State)  28d. Certifier 28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Certifier 28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Certifier 28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State	or, p	25. Wes case referred to medical 26. P	Place of Death (Check only o	
27. Menner of Death 1 Disjatural investigation 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury et Work? 1   Yes 2   No 28c. Injury et Work? 1   Yes 2   No 28c. Injury et Work? 1   Yes 2   No 28c. Injury et Work? 28c. Injury et Wor	O G	examiner? Other:	1/	
30. Name and address of persentant completed course of persentant completed course of persentant (Item 23a) (Type, Print)  James C. Boyd, MD. California, Maryland 20619	5 8			
30. Name and address of person and completed course of person and cours	to the	Totalural Surerioling	2 🗆 No	
30. Name and address of persentant completed course of persentant completed course of persentant (Item 23a) (Type, Print)  James C. Boyd, MD california, Maryland 20619	Director Jin by the	3 Suicide  8 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office	28f. Location (S City or Tox	Street and Number or Rural Route Number, wn, State)
30. Name and address of persentanc completed course of persentance completed course of persentance of persentan	• Funeral • Funeral letely fille	(Check only   Medical Examiner: On the basis of examinetion end/or investigation, in my opinion.		
30. Name and address of persentanc completed course of persentance completed course of persentance of persentan	Me Me	29b. Signature and title of certifier 29c. License numb	per	29d. Date signed (Month, Day, Year)
James C. Boyd, MD California, Maryland 20619	s F 0	N Ia G	217	0/2/100
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State of Maryland / Department of Health and Mental Hygiene

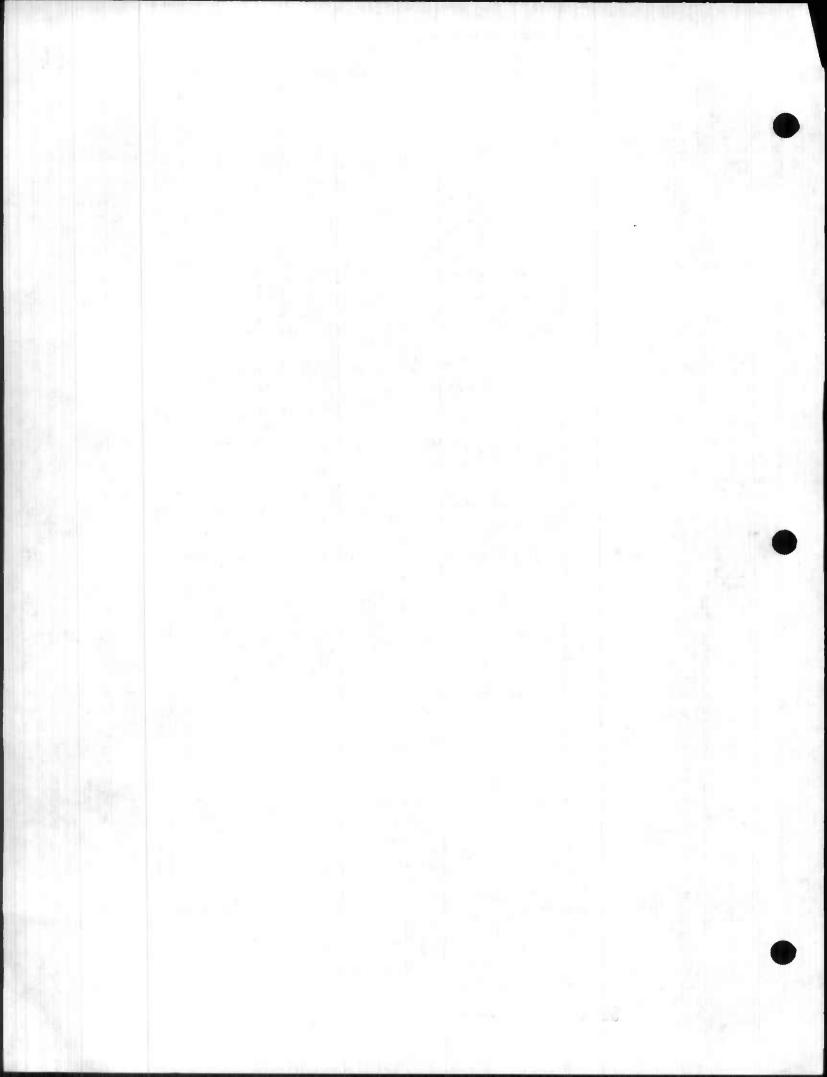
32594 Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) 2. Dala of Death Day **Physician** September 22,2000 Michael Kahl. 3:30 AM Raymond /Medical 4b. City, Town, or Location of Death 4e Facility Nema (If not institution, giva street and number) 4c. County of Death Examiner Baltimore 9021 Kahl Avenue Perry Hall If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 6. Sex 1⊠M 2□F 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foreign **Funeral** Months Yrs. 215-32-2590 75 Jan. 16, 1925 Maryland Director Usuel Rasidence of Decedant 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Norris 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Perry Hall Baltimore. Directo Maruland 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? U.S.A. 21128 9021 Kahl Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Dalas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, alc. filed within 72 hours after 1 Nevar Married 2 Married Saltimore, Maryland 21215-0020 8 1 ☐ Yas 2 X No Specify: Specify: py White 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Baltimore County Elamentary/Secondary (0-12) Collega (1-4or 5+) Recreation and Parks 10th Grade Supervisor 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fether's Name (First, Middla, Last) Pages 1 and 2 should be Mental Schrenker Joseph Kahl Magdalene and a 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 9021 Kahl Avenue, Perry Hall, MD 21128 Mrs. Erma F. Kahl (wife) Department of Health Important: If Item 27 20b. Plece of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Dala 1 X Burial 2 Cramation 3 Ramoval from Stala Joseph Church Cem. 9/25/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility
Schimunek Funeral Home, Inc.
9705 Belair Rd., Baltimore, MD 21. Signature of Funaral Sarvice Licensee Ci. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. CANCER **Physician** NON SMALL CELL LLING Immediata Causa (Final disaasa or condition rasulting in death) /Medical 2 MONTHS Examiner Dua to (or as a consequence of) Physician/Medical Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequanca of): use es the burial-tre Box 68760, Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? P.O. director, page 2 should be detached Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No signed by Division of Vital Records, Be Completed by 24b. Wara autopsy findings available prior to complation of cause of daalh? 24a. Was an autopsy this certificate hes 2/2 No 1 ☐ Yas 2 ☐ No 1 Yas To the Hospital or Attending Physician: within 24 hours effer deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director; s 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/OutpalienI 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) Medicai Certification: To 1 Yas 2 No 27. Manner of Death 28a. Dala of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 1 (DNatural 5 Panding invastigation 2 🗆 No 1 Yas 2 Accidant 6 Could not be detarmined 3 Suicide 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Dala signed (Month, Day, Year) 25b. Signature and title of certifie 29c. Licensa number 10 person who completed causa of daath (Item 23a) (Type, Print) SWANDS 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State

**DHMH 16 Rev 6/95** 

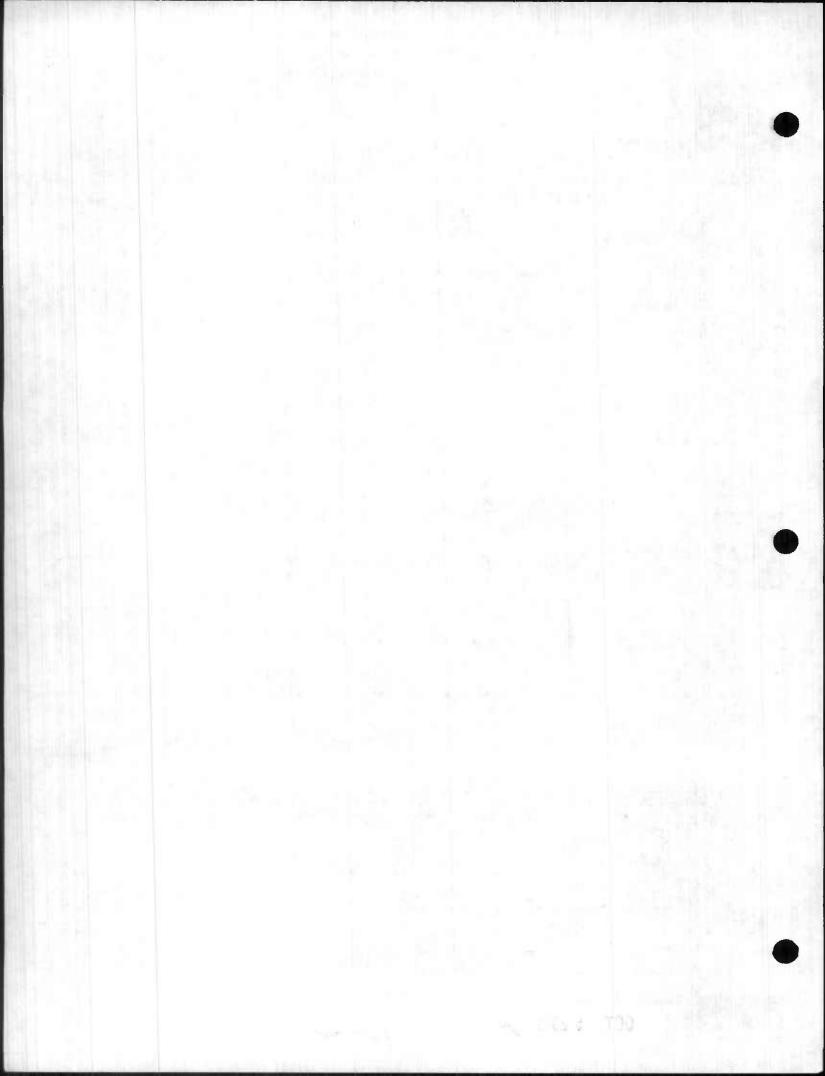
Registrar

26



State of Maryland / Department of Health and Mental Hygiene 00 325

		1. Decedent's Nam	ne (First, Middle, Les	st)		Cert	ificate o	f Death	2. Dete of Dec			595 Time of Death
Physic		Edwin Li	ncoln Kin	kaide					Octobe	r 4, 200	Year	0200
/Med Exam			If not institution, give		r)		H II.	4b. City, Town, o	r Location of Deeth			0200
EXUIII		Heron Po	int					Chester	ctown	Kent		
Funera Directo		5. Social Security N 121-09-4	584	ex 7. A	ige (In yrs. 83	lest birthdey) Yrs.	If Under 1 Yes Months Dey	r If Under 24 Hr	8. Date of Birt (Month, De February	12, 1917	9. Birthplaca Country) Glenwood	(State or Foreign 1, New York
how		Usuel Residence o 10a. Stete	10b. County	THYS.	10c. C	ty, Town or Loca	ation					Inside City Limits
Ma Trans	ctor	Maryland	Kent		CI	nestert	own					Yes 2□No
th th	)ire	10e. Street and Nu	mber	4 140			10f. Zip Code		110	10g. Citizen of V	het Country?	
23a	18	215 Heron	n Point				216	20		USA		
Maryland 4.14.15-0020 nd 2 should be filed within 72 hours after deeth with the Maryland lith end Mental Hygiene. 27 Is marked other than "natural", or thems 23s or 28s-4 show r treumstic event, the Market Examinal must be notified at	by Funeral Director	11. Meritel Stetus  1 □ Never Merr  3 ☑ Widowed	ried 2 Merried	12. Wes Deceder Armed Forces 1 Yes 2 the Yes, Give Year or Dates	No		as Decedent of Yes, specify Cu ☐ Yes 210 N		(Specify Yes or No orto Rican, etc.)		e - American Ir k, White, etc. : White	
72 ho	Completed	(Sne	15. Decedent's Ed	lucation		16e. Decede	nt's Usuel Occ	upetion e during most of w	rodkina	16b. Kind of Bu	siness/Industr	у
N E . S	npie	Etementery/Seco		College (1-4o	r 5+)	life. Do	O NOT use reti	red)				
filed with Hygiene. Ther the	Co	12		4		Sales Ma	nager/In	lustrial Me		Pipeline/		as
107e, Marylana Z1Z ges 1 end 2 should be filed within t of Health end Mental Hygiene. If frem 27 is marked other than or other treumatic event, the M	Be		(First, Middle, Last)						eme (First, Middle,	maiden Sumem	Θ)	
should be nd Mental marked o	10		Kinkaide					Sarah F	-	0: 7	2: 2: 2:	4.1
Mar 32 sh h end 7 le m treum		Perry Kin	eme/Reletionship (7	ype, Print)					Rural Route Numbe			
1 end 1 Health em 27 Ither tr		20e. Method of Dis			20b.	Plece of Disposi		rescent St.	Albert, A	20c. Location -		
Pages nent of mr: If he		1X Buriel 2	☐ Cremetion 3 ☐ 5 ☐ Other (Specify			cemetery, creme	story or other p		C 10/4/2000			
Baltimore, permit. Peges 1 er Department of Hea Important: if item any injury or othe	Department of Health Important: If them 27 any injury or other to page.	1/	unerel Service Licen	11111	0	22. Fo.]	Name end Add	I forboin S	Norman Elec	wal Lloma	D A	
Physician /Medical Examiner		shock, or head Immediate Cause disease or condition resulting in deeth)	the diseese, or comp int failure. List only (Finel		2F		mouse		mencina			proximate ervel Between set end Deeth
aeth certificate be axecuted attending physician and for use as the burial-trensit	n/Medical Examiner	Sequentially list co if any, leeding to in cause. Enter Unde Ceuse (Disease or that Initiated eventure resulting in death)	Injury	b		or es e consequ or es e consequ						
death cert e attending od for use	cla	Part II Other elanit	ficant conditions of	ontributing to death	but not rea	culting in the unc	forhving cause	niven In Pert I	23h Did	lohacco use cor	atribute to the	cause of death?
detache	/ Physician/M	Tottii. Other signi	Totali conditions of	Arthourng to deeth	Dut Hot 16:	sulting in the unit	onying cause	givon in rotti.		Yes 27 No	3 Probabl	
VICAL THE COLUMN, F. C. DOX solution: The law requires that the death cer certificate has been signed by the attendinisetor, page 2 should be detached for use	Completed by									en autopsy med?	aveilab	eutopsy findings ble prior to etion of cause th?
The The page	Con								10	res 20 No	1 □ Ye	s 2 No
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		30. Name and addr		nom-loted source of	death (Ita	- 00a) (T D						
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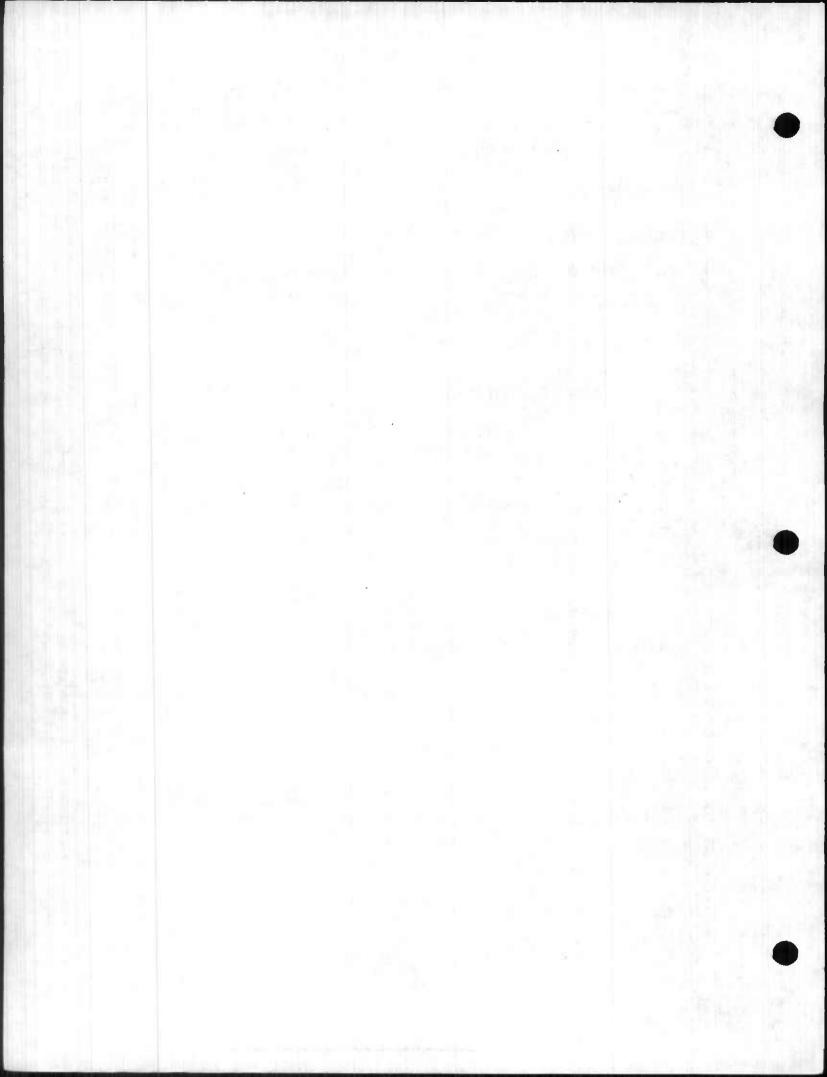
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Examir	ner	12430 Augusti									Death
		5. Social Security Number	6. Se		7. Age (In yrs.	last hirthday)	If Under 1 Yaar	ennedyvi.	I LE 8. Data of Birt	Kent	Birtholace (State or Foreign
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anyland show d.st		10a. State 10b. C				y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X No
No M	Directo	-	ent		Ke	nnedyv	T				
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F 22 H	brai	12430 August:				10 10 1	216		a ait . Vaa aa Na	USA	American Indian,
ours after death w elf, or literie 23s Examiner mant	by Funeral	11. Marital Status  1 Never Married 2 3 Widowed 4 Div	Married	Armed For 1 Yes If Yes, Give Year or Da	<b>₹</b> [No		Yes, specify Cubi	dispanto Origin? (Sp an, Mexicen, Puarto Specify:	Rican, atc.)	Black, Specify:	White, etc. White
d 2 should be find within 72 hours at this and Andrea i hydronia i hydronia i hydronia naturali, or traumatic event, the Medical Exam.	Completed	15. De (Specity only Elementary/Secondary (		cetion completed) Collega (1	4or 5+)			eation during most of world)	king	16b. Kind of Busin	
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o d be	o Be	Hans Geissdon						Kate Sc			
d Model	ř	19a. Informant's Name/Rei		ne Print)		19h Mailin	o Address /Street	and Number or Ru		or City or Town St	tate Zin Code)
79.00					Uuahan	1 10000					11e, MD 21645
- 2 2 2 2		20a. Method of Disposition	ретша	1, 01.7	20b. F	Place of Dispos	sition (Nama of		Date Date	20c. Location - Ci	
emit. Pages 1. Appartment of Ho mportant: if ther my injury or oth	2	1 X Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ Ot		emoval from 5	state		Cemetery Cemetery			00 Baltim	
permit. Depart Import any inj		21. Signature of Funeral S 23a. Part1. Enter the disease	121	11/1	20	Fe]		ss of Facility elfenbein	& Newna	m Funera	1 Home, P.A.
Medical Examiner of the system and ging physician and as the burial transit	Medical Examiner	Immediata Causa (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· { '	. Am	Due to (d	or as a consequence or a con	uence of):	35 with Failure	Kespi	'ratory	2 years
e death certif the attending hed for use a	an										
at the de d by the etached	Physician/M	Part tt. Other significant co	onditions con	tributing to de	ath but not res	ulting In the ur	nderlying ceuse giv	ven in Part I.		- (	ributs to the cause of death?
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requir been s should	Completed	Wolders	ronol	loerog	gather Cobeles	enici				an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
	Eo	Temporal	ante	ution					10	res ZÓNo	1 ☐ Yes 2 ☐ No
ica i.	Be C	25. Was cese referred to m	nedical					26. Piace of Daa	th (Check only o	one)	
E 2		examiner? 1 ☐ Yes 25 No	F	lospital:	patient 2	ER/Outpatien	t 3 DOA Oth	ar	1	dence 6 Other	(Specify)
raician: The s certificate director, pag		27. Manner of Death		28a. Date o		28b. Time of Injury	28c. Injui			now injury occurred	
this seld	€ 6 2	2 Accident	Pending investigation						004 1 2 4		
£ 50		2 Accident		28e. Place buildin	of Injury - At h	ome, farm, stre (y)	eet, factory, office		City or To	Street and Number vn, State)	or Rural Route Number,
£ 50		2 Accident 3 Suicide 4 Homicide  29a. Certifier	could not be determined	buildin	best of my kno	bwledge, death	occurred at the til	me, date and place opinion, death occu	City or To	vn, State) cause(s) and manr	
£ 50	Medical Certification:	2 Accident 3 Suicide 6 6	investigation Could not be determined ortifying Physical Examin	buildin	best of my kno	bwledge, death	occurred at the til	ppinion, death occu	, and due to the rred at the time,	cause(s) and manr date and place, an	ner as stated.
Attending Ph or deeth. ector: After th by the funerel	edical Certification:	2 Accident 3 Suicide 6 6 4 Homicide  29a. Certifier (Check only one)	investigation Could not be determined ortifying Physical Examin	buildin	best of my kno	bwledge, death	occurred at the tit restigation, in my o	ppinion, death occu	, and due to the rred at the time,	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 00 32597

			Certifica	te of Death		Reg. No.	02001
Diam'r inian	1. Decedent's Name (First, Middle, Las	()			2. Date of Dee	Day Yea	3. Time of Death
Physician /Medical	Melvin Edgar L	ederer, Jr.			Septemb		
Examiner	4s Facility Neme (If not institution, give	street and number)		4b. City, Town, or	Location of Death	4c. County of De	eth
	Fallston General		1 411	Fallstor		Harf	
Funeral	5. Sociel Security Number 6. Se	XM 2DF	last birthday) If Und Month	er 1 Year If Under 24 Hrs Deys Hours Min.			Birthplace (State or Foreign Country)
Director	218-26-6188 Usuel Residence of Decedent	69_	113.		Oct. 14	1, 1930 Ma	ryland
pa a	10a. State 10b. County	10c. City	y, Town or Location				10d. Inside City Limits
Manylar 4 show	Maryland Harfor	n.	01 7im				1 ☐ Yes 2 No
with the Maryland is or 28s-f show Les routified at	10e. Street and Number	u be	el Air	ip Code		10g. Citizen of What	Country?
23a or	1205 Fordham Ct	14.71	2	1014		US	7)
offer deeth v	11. Meritel Stetus	12. Wes Decedent Ever in U,	S. 13. Was Dec	edent of Hispanic Origin? (S	Specify Yes or No-	14. Race - Ar	merican Indien,
or he		Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give		ecify Cuben, Mexican, Puer	to ricen, etc.)	Black, W	
D # 19		Yeer or Dates: Korea	an   1   Yes	No Specify:		Specify:	White
E 1215-0 ed within 72 ho ygiena. Ner than "naturi ft, the Medical Completed	15. Decedent's Edu (Specify only highest great	ucation de completed)	16a. Decedent's Us	uel Occupation work done during most of wo	rkina	16b. Kind of Busines	ss/Industry
within within then the key	Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retired)		T = 3 = 1 = 1 = 1	1
offied with the other the vent, the		3	Owner/0	Operator			l Motor Sale
Do die	17. Father's Neme (First, Middle, Last)	- 1				Maiden Sumeme)	
Maryland of 2 should be filed the end Mental Hyg 7 is marked other treumatic event.					Ellen		
Maryland d2 should be flie h end Mental Hy le marked oth treumatic event To Be (	19a. informent's Neme/Reletionship (T)			ss (Street end Number or R			
- 5 8 0 7	Carol Lee Ledere  20e. Method of Disposition		1205 FO	rdham Road, F	Bel Air,	Maryland 20c. Location - City	
altimore mit. Peges 1 o partment of He portant: if ther y Injury or oth	1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from Stete	remetery, cremetory or	other plece)		T10 - 12W	
Saltim	4 Donetion 5 Other (Specify,		lltop Serv		9-29-00	Towson, M	aryland
Baltimore, semit. Peges 1 e Separtment of He mportent: If them my Injury or other most.	21. Signature of Funeral Service Licens	51		ond Address of Facility Omas Funeral	Home, P.	Α.	
4020	marle a.	inge	131	7 Cokesbury F	Road, Abi	nadon, Ma	ryland 21009
	23a. Pert1. Enter the disease, or comp shock, or heert feilure. List only of	lications that caused the death one ceute on such line.	h. Do not enter the m	ode of dying, such es cardia	c or respiretory ar	rest,	Approximete Interval Between
Physician							Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	· ACUTE	RENA	L FAILU	RE		1
DEED 5			er as e consequence o				
The red		0.	S SYNO				1
60, Holisan end be axecuted burial-transit	Sequentially list conditions, if eny, leeding to immediate ceuse. Enfer Underlying Ceuse (Disease or Injury	Due to (o	r es e consequence o	):			1
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ox 68/6/ certificate be rding physicis use as the bu		Due to (or	r as a consequence of	).			
BOX ath certing for use e		d					į.
death death ad for u	Pert II. Other significant conditions co	intributing to death but not rec	ulting in the underlying	course given in Bart f	23h Did i	tohacco use contribu	ute to the cause of death?
o the school	Forth. Other significant conditions co			Couse given in Fait I.			Probably 4 Unknow
s thet s thet y	Metastatic 1	rostate co	encer,				
DIVISION Of VITAL RECORDS, P.O. BOX or attanding Physician: The lew requires that the death cerefice death.  Director: After this certificate has been signed by the ettending in by the funeral director, page 2 should be detached for use extification: To Be Completed by PhysicianA	Diseminated.	Totalle	10- 1	- 1. 1	24e. Wes	en eutopsy 24	b. Were autopsy findings available prior to
s bee	Discontinuity	snira vas et	THE COL	3014/10-	pono	anneo!	completion of ceuse of deeth?
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vital Rec sician: The lew certificate has t director, pege 2 s				26. Plece of De	eth (Check only o	one)	
OT VITA Physician: this certific ral director,	examiner?	Hospifal: 1 Impatient 2	ER/Outpatient 3 1	Other		dence 6 □Other (S	pecify)
Physical of Price of Physical of Price		28e. Dete of Injury (Month, Dey Year)	28b. Time of	28c. Injury et Work?	· · · · · · · · · · · · · · · · · · ·	how injury occurred	
Attending r death. Sctor: Affe fune by the fune fill cation	1 DNeturel 5 Pending 2 Accident investigation		Injury M	1 Yes 2 No			
After Appendix of the by the b	3 Suicide 6 Could not be determined	289. Piece of injury - At no	ome, farm, street, fact	ory, office	28f. Location (S	Street and Number or	Rurel Route Number,
DIVISION C ball or Attending P rs efter death. el Director: Aftert led in by the funers Certification:	4 D Hollidge	building, etc. (Specify	y)		Chy or ros	411, 31616)	
hours hours hours y fille	29e. Certifier 1 Certifying Phy	rsician: To the best of my kno					
DIVISION Of VITA To the Hospital or Attanding Physician: within 24 hours effer death. To the Funeral Director: Affer this certifica completely filled in by the funeral director, Medical Certification: To Be (	(Check only 2 Medical Exami	iner: On the basis of exeminer end menner steted.	tion end/or investigation	on, in my opinion, death occ	urrea et the time,	gete end place, and o	tue to the ceuse(s)
within To the Comp	29b. Signeture end title of certifier	4	2	9c. License number		29d. Date signed (Mo	
	7/1	a mo		035012	-	September-	28,2000
12	30. Neme end address of person who c	completed cause of deeth (Item	n 23a) (Type, Print)	SILLS SELECT			
10	J. Kevin Lyni	ch mo	2 North	Ave. Bel	Air,	Md. 2	1014.
State	31. Dete filed (Month, Dey, Year)	/32. Regisfrar's Signe	oture				
Registrar	OCT 1 - 2000	Denve	D. Ana	Mal			

MELVIN E. LEDERER



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32598 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Date of Death Month **Physician** Arthur Liberatore Sept. 2000 28 6:55am /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Havre de Grace 101 Vandiver Court 5. Social Security Number if Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Min 1 X M 2□ F Devs Hours Yrs. 215-16-9438 11/20/1922 Waryland Director Usuel Residence of Deceden death with the Marylend 10d. Inside City Limits 10a State 10b County 10c. City. Town or Location th end Mental hygiene. 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Modical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 USA 101 Vandiver Court Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Americen Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health end Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Year or Dates: WW7 Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government Machinist 12th 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Be Lucia DiGuilio Pasquale Liberatore 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) nt of Health e if Itsm 27 is or other tre 411 Quaker Bottom Rd., Havre de Grace, iAD 21078 Katherine Marron- Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other placa) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removel from State permit. Page Department of Important: If any Injury or once. Mt. Erin Cemetery 10/2/00 Havre de Grace, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme and Address of Facility 21. Signeture of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A. MD 21078 123 S. Washington, Havre de Grace, 23. Fort Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final months disease or condition resulting in death) **Examiner** Dy e to (or as a consequence of): Examiner that the death certificate be axecuted physician end s the buriel-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as e consequença of) ettending ph signed by the e Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 24 hours ofter death. Funeral Director: After this certifica director, Be 25. Wes case referred to medicel 26. Plece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 S Aesidence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funaral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation iniun 1 Netural 1 Yes 2 🗆 No 2 Accident 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier edical To the within 2 29b. Signature and title of cartifier 29d. Date signed (Month, Dev. Year) 29c. License number

MacPhail Rd. Bel Air, MD

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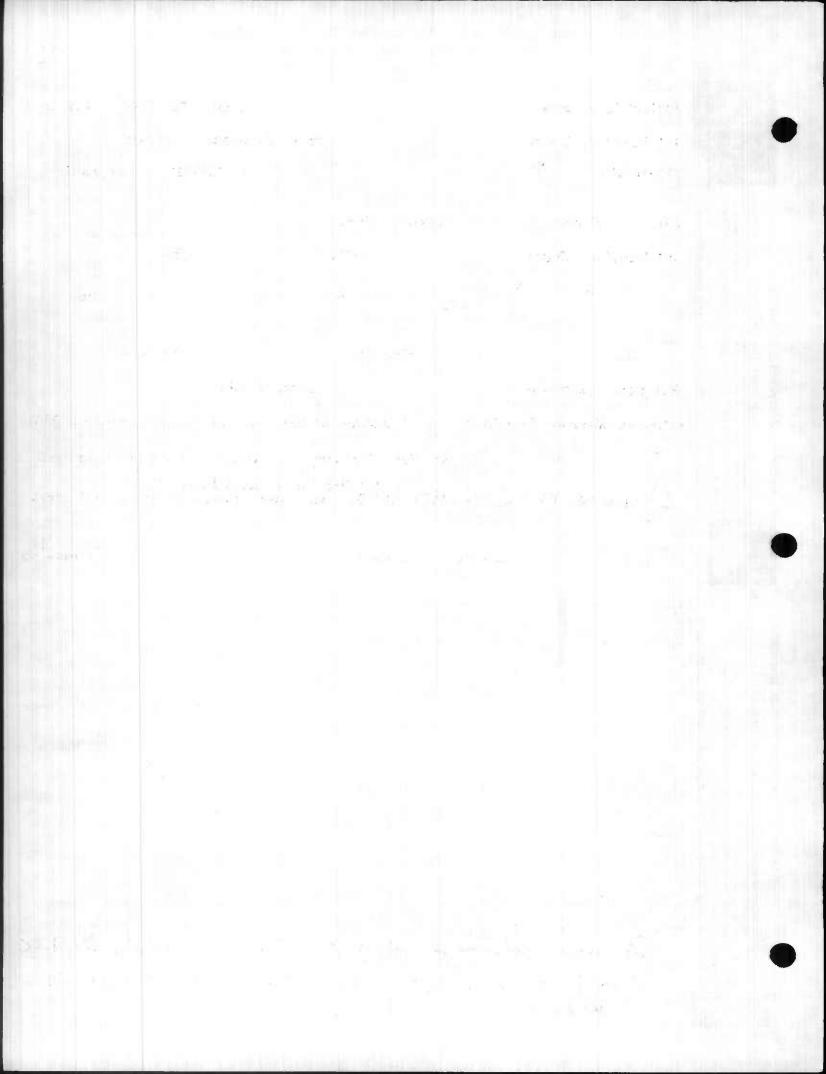
State Registrar

31. Dete filed (Month

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

IMPERS

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

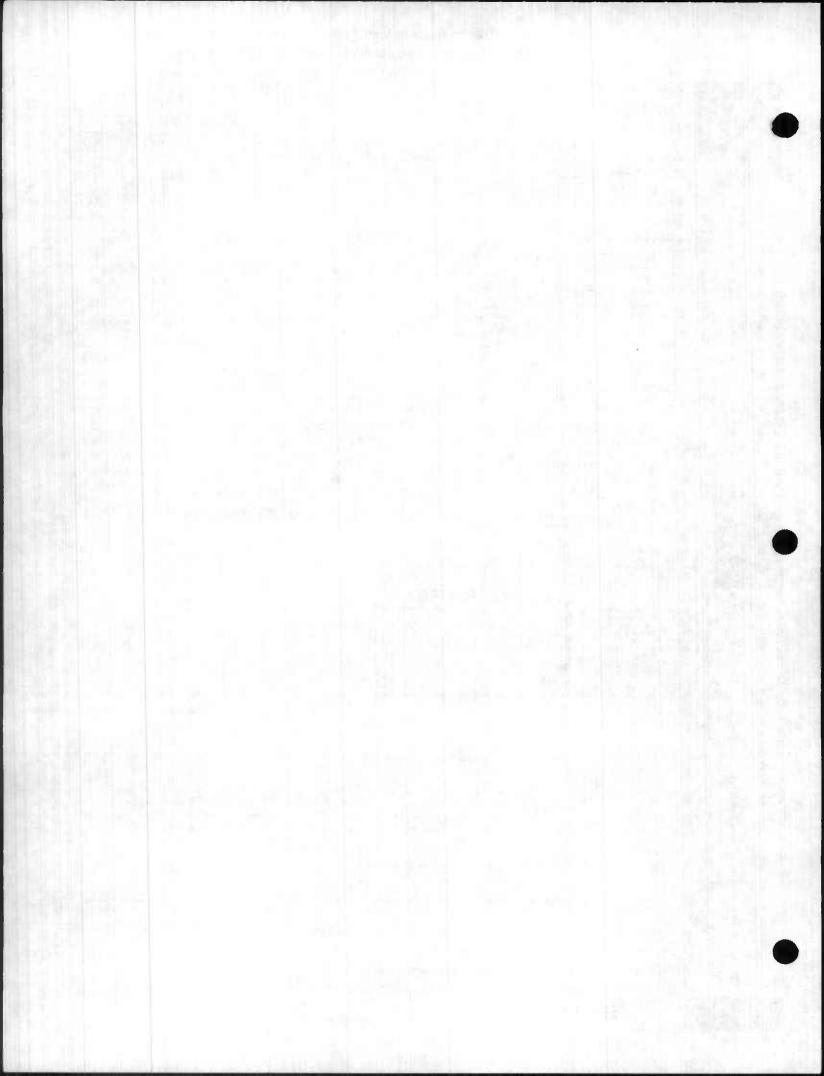
Certificate of Death

32599

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Dhunini		1. Decedent's Nerr	ne (First, Middle, L	ast)					2. Dete of D		3. Time of Death
Physici /Medic	_	Gerald	Edward L	ampe		11.00	2120		Septer	mber 22,	2000 3:15 p.m
) Examir		4a Facility Neme (	(If not institution, gi			ST HOS	PITAL		n, or Location of Dea KVILLE		of Death [GOMERY
Funeral Director		5. Social Security F 577-12-	Number 6.	Sex 1⊠M 2□F	_	s. lest birthdey) Yrs.	1 477		Hrs. 8. Date of Bi Min. (Month, D May 11		Birthplece (State or Foreign Country)     New York
		Usual Residence of	of Decedent		02				12		
show		10e. Stete	10b. County		10c. C	City, Town or Lo	ocation				10d. Inside City Limits
Mar Mar	tor	MD	Montgo	mery	Ro	ckville	9				1⊠Yea 2□No
r 28	Director	10e. Street and Nu	imber				10f. Zip Code			10g. Citizen of V	Whet Country?
death with the Maryland ms 23a or 28a-f show mar be notified at	al	1110 Pa	rrish Dr	ive			20	851			USA
5 2 2	by Funeral	11. Meritel Stetus 1 Never Meri	ried 27 Merried	Armed F	cedent Ever in to				n? (Specify Yes or N Puerto Rican, etc.)		e - American Indien, ck, White, etc.
urs of it.	by	3 Widowed	4 ☐ Divorced	If Yas, G Yeer or I	Detes: WW	2	1□Yes 2⊠N	o Specify:		Specify	white
15-UUZU 72 hours after "natural", or the	Completed	10	15. Decedent's E	Education	n	16e. Dece	dent's Usual Occ	upation	of working	16b. Kind of Bu	usiness/Industry
	ple	Elamantary/Sec	ondary (0-12)		(1-4or 5+)	life.	DO NOT use reti	red)	or working		
G 2727 filed within Hygiene. ther than	NO.	10 th				Carper	nter			Home I	mprovement
Maryland 21215-0020 Id 2 should be filed within 72 hours af th and Mental Hyglene. It is marked other than "natural", or treumatic event, the Medical Exam	Be (	The state of the s	(First, Middle, Las			77.5			s Name (First, Middle		10)
yian build be Mental arked o	To	Charles	H. Lamp	е				Isabe	elle M. Pe	rry	
Saryia 2 should and Men is marke summatic		19e. Informent's N	leme/Raletionship	(Type, Print)		19b. Maili	ng Address (Stre	et and Number	or Rural Route Num	ber, City or Town,	Stete, Zip Code)
and 2 and 2 aalth a		Margare	et A. Lam	pe/wife		1110	Parrish	Dr., R	ockville,	MD 208	51
of He man		20e. Method of Dis	sposition		20b.	Plece of Dispo	osition (Name of	niace)	Dete	20c. Location -	City or Town, Stete
Pages nent of nt: If it			□ Cremetion 3   5 □ Other (Spec		Stete AS		ade Cem.	Sept	26, 2000	Friend	sville, MD
DESILIMOTE, MATYIGHO ZIZ.  permit. Pages 1 and 2 should be filed within Department of Health and Mental Hydene. Important: if item 27 is marked other than any injury or other traumatic event, that and note.			uneral Service Lice				2. Neme and Add		Iomes, P.A	., PO Bo	x 275
		Na	au 07	eum	an	1.	79 Mille	r St.	Grantsvil	le, MD	21536.
<u></u>		23a. Pert1. Enjer shock, or he	theldiseese, or cor ert eilure. List onl	nplications that y one ceuse on	each line.	eth. Do not en	ter the mode of t	lyting, such as c	erdiac or respiratory	arrest,	Approximate Intervel Batwean Onset end Deeth
Physician											Offset end Deetn
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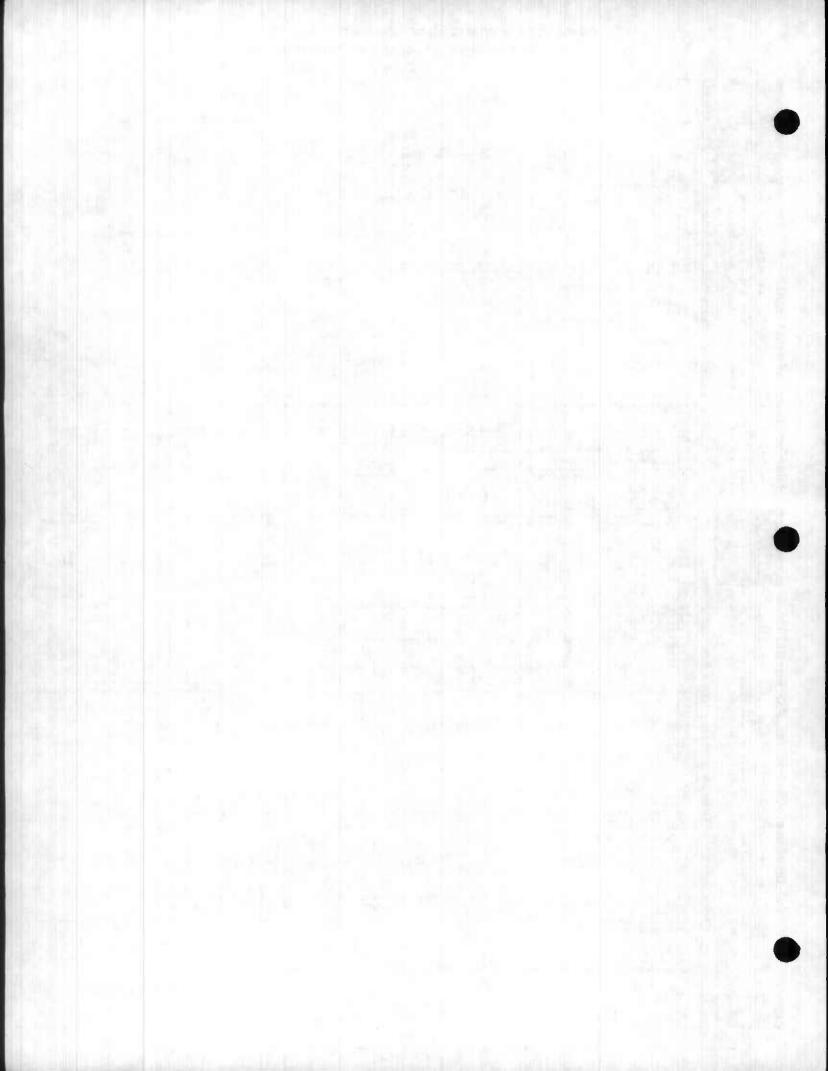
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Registrar



State of Maryland / Department of Health and Mental Hygiene 00 32600

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State of Maryland / Department of Health and Mental Hygiene

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0018 - 2000 Process D. Person

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certific	ate of	Death		Reg. No.	IU	32602
Physician	1. Decedant's Name (First, Middla,	, Last)			=	E 24	2. Data of D	eath Day	Yaar	3. Tima of Death
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edical	Sequantially list conditions, if any, leeding to immadiata cause. Enter Underlying Cause (Disease or injury that initieted evants resulting in deeth) Last	· Hemi	Due to (or as	a consaquanca	of):	Serct Serct	1 60	mie'		1day 1day
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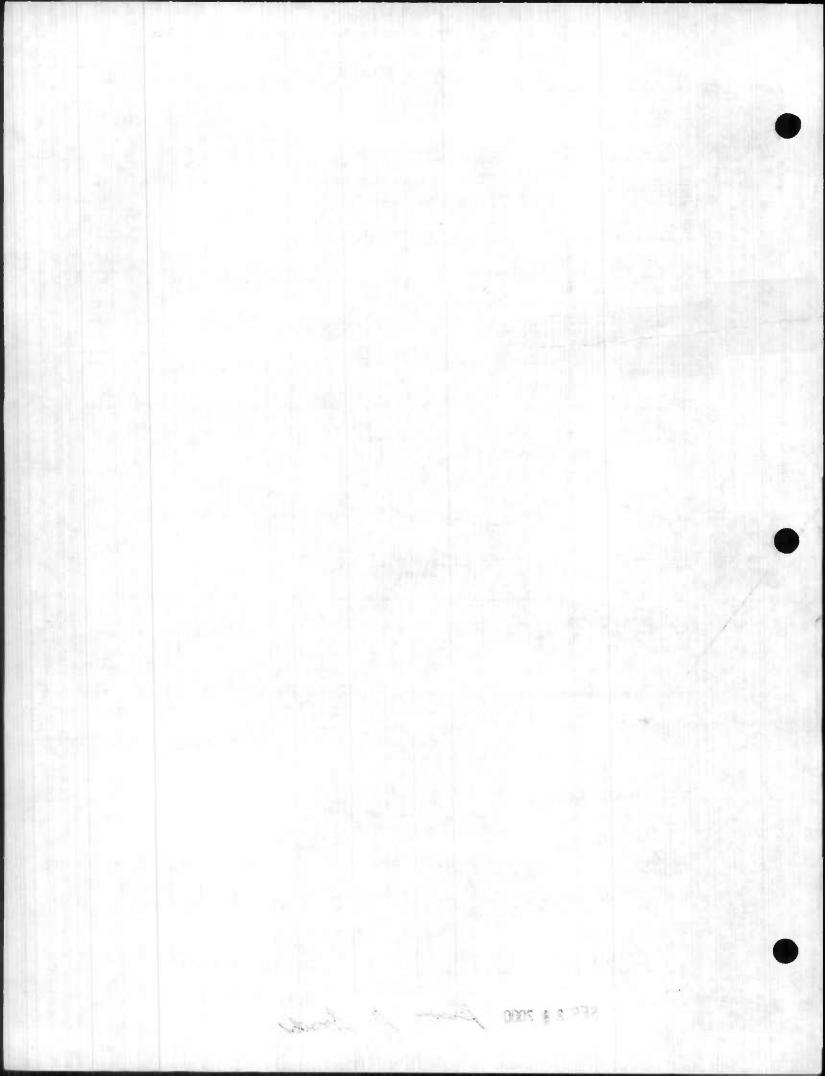
to make

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

32603

cian				Ocitii	icale of	Death		Reg. No.		
	1. Decedent's Neme (First, Middle, La						2. Dete of E Month	Day	Year	3. Time of Death
dical	Thomas Merci						Septen	34 040	000	3:00 AN
iner	4a Facility Name (If not institution, gi					4b. City, Town, o		ath 4c. County	of Death	
	University of Maylan					Baltim		Balti		
at		Sex 7. Aga	(in yrs. last be	M	Undar 1 Year onths Deys	Hours Mi		Birth Day, Year)	9. Birthpl Coun	lace (Stete or Foreign try)
r	221-28-8166	53		Yrs.			Oct.	10, 1946	USA	
	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	m or Locati	nn.				11	Od. Inside City Limits
	Too. County				011					ty⊠oves 2 □ No
rector	Maryland Kent		Rock H	-						Λ.
5	10e. Street and Number			1	Of. Zip Code			10g. Citizen of \	What Coun	try?
=	6412 Edesville Rd				21661			United	State	es
Fune	11. Marital Status	12. Was Decadent En	var in U,S.	13. Was	Decedent of I	dispanic Origin?	Specity Yes or hito Rican, etc.)	No- 14. Rad	e - Americ ck, White,	
07257-0	1 Never Merried 2 Married	1 Yas 2 No		10	Yes 20 No	Specify:		Specify	<i>r</i> :	
d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:							Whi	
919	15. Decedent's E (Specify only highest gr	ducation ada completad)	168	. Decedent (Giva kind	's Usual Occup of work done	pation during most of w d)	orking	16b. Kind of B	usiness/Inc	fustry
Completed	Elementery/Secondery (0-12)	College (1-4or 5+				d)				
8	9yrs		E	ainte	r			Paint		
Be	17. Father's Nama (First, Middla, Last					18. Mother's N	ame (First, Midd	le, Maiden Sumen	10)	
100	Thomas Henry Merc	er				Mary	Chadwic	k		
	19a. Informant's Name/Relationship		19	b. Mailing A	ddress (Street	end Number or i	Rural Route Nun	ber, City or Town,	Stete, Zip	Code)
	Tonya L. Mercer	(daughter)		6412	Edesv	ille Rd.	Rock H	all, Md.	2166	1
	20a. Method of Disposition		20b. Place	of Disposition	on (Nema of		Date	20c. Location		
	1 Sparial 2 Cramation 3 Department 2 Donation 5 Other (Speci			*	metery		9/29/0	Rock Ha	11	
-	21. Signature of Funeral Sarvice Lice		WEST				1	1		
	11	11						wnam Fun		
	23a. Part 1. Enter the disease, or con	llare	h - d - th D-	370	W. Cy	press St	. Milli	ngton, Mo	1. 21	651 Approximate
	Shock, or heart failure. List only	one cause on each line	ne deein. Do	not enter tr	ie mode or dy	ng, such es card	ac or respiratory	errest,	1	Interval Between Onset and Deeth
	Immediate Cours (Final	4							1	
	Immediata Cause (Final disease or condition resulting in death)	· Acute	Myo	cardio	al In	farction			1	5 days
-	resulting in death)		Due to (or as a	consequer	ice of):				1	
Examiner		b		N 36						
кап	Sequentially list conditions,	C	oua to (or as a	consequer	ica of):					
	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury									
Medical	that initieted events resulting in deeth) Lest	D	ua to (or as a	consequan	ce of):					
Me										
an/		0								
Physician	Part II. Other significant conditions	contributing to death but	not resulting	in the unde	rlying cause gi	ven in Part I.	23b. D	d tobacco use co	ntribute to	the cause of death
F.							11	Yes 2 No	3 Pro	bably 4 Unknow
by							-		_	
							24a. W	as an autopsy rlormed?	av	ere autopsy findings allable prior to
Die									co	mpletion of causa death?
Completed							1[	Yes 2 No	10	Yes 22No
9	25. Was case referred to medical					26. Place of D	eath (Check on)	v one)		
	examiner? 1 ☐ Yas 2 ☑ No	Hospitel:	t 2 ER/C	utnationt	3 DOA O	hor		sidenca 6 Ott	ner (Specif	VI
00		28a. Dete of Injury	28b.	Time of	28c. Inju		7	e how injury occur		,
ToB	27. Manner of Death	(Month, Dey	Year)	Injury		ork? ]Yes 2□No				
ToB	27. Manner of Death  1 Neturel 5 Pending	on l			fectory, offica		28f. Location	(Street end Num	ber or Rura	al Route Number,
ToB	27. Manner of Death  1 Neturel 5 Pending investigetic investigetic 3 Suicide 6 Could not to	OB Place of Injur	ry - At home 1	arm, street				Cara-i		
ToB	27. Manner of Death  1 Neturel 5 Pending 2 Accident investigation	OB Place of Injur	ry - At home, t (Specify)	arm, street,			City or	own, State)		
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death Month Michael A. McClintock October 2000 3:50 PM 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 128 Ravine St. Grantsville Garrett 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. Birthpiece (State or Foreign Country) 8. Date of Birth (Month, Day, 1⊠M 2□ F Months Days Hours 35 Yrs. 178-60-0115 03/03/65 PA Usual Residence of Dacedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Garrett Grantsville 1 Tyes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 128 Ravine St. 21536 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2⊠ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 11. Maritai Status 1 Navar Married 2 Married 1 Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collage (1-4or 5+) 12 Iron Worker Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumame) Larry McClintock Linda Stairs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Numbar, City or Town, Stata, Zip Code) Karen McClintock/Spouse 128 Ravine St., Grantsville, MD 21536 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 ☑ Cremetion 3 ☐ Removel from Stete Countryside Crematory 10/09/00 4 ☐ Donetion 5 ☐ Other (Specify) Davidsville, PA 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Humbert Funeral Home P. 0. Box 37, Confluence, 23a. Part1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. Ust only one cause on each line. PA 15424 Approximata Interval Between Onset and Death Immediate Cause (Final colon carcinoma with metastasis one year disease or condition rasulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 25. Was casa referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

physician

certificate hes

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After t

Hospital To the Hospital within 24 hours of To the Funeral Completely filled

**Physician** 

/Medical

**Examiner** 

Director

Funeral

by

Be Completed

10

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

the Maryland

with

death

Pages 1 end 2 should be filed within 72 hours after nent of Health end Mental Hygiene.

nd Mental Hygiene. marked other than

27 is marked traumatic e

nt of Health e If Item 27 is or other tra

Depertment Inportant: If any injury or

Baltimore, Maryland 21215-0020

for use es the buriel-tran ettending the page 2 should be detect director. Iuneral I ofter death.
I Director: Af

The law requires that the death certificate be executed

Records, P.O. Box 68760,

Division of Vital or Attending Physician:

Examiner Physician/Medical þ Completed Be To Certification: filled in by

Other: 4 ☐ Nursing Homa 5 € Residence 6 ☐ Other (Specify) - 1 □·Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 28d. Describe how Injury occurred

27. Mannar of Death Data of Injury (Month, Day Year) 28b. Time of Injury 1 Naturai 5 Pending investigation 2 Accident 6 Could not be determined 3 Sulcide

28c. Injury at Work? 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signeture and lifle of certifie

Karl E. Schwalm, M.D.

29c. License number

D27205

29d. Dete signed (Month, Day, Year)

10/05/00

30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print)

311 N. Fourth St 21550 Oakland, MD

State Registrar

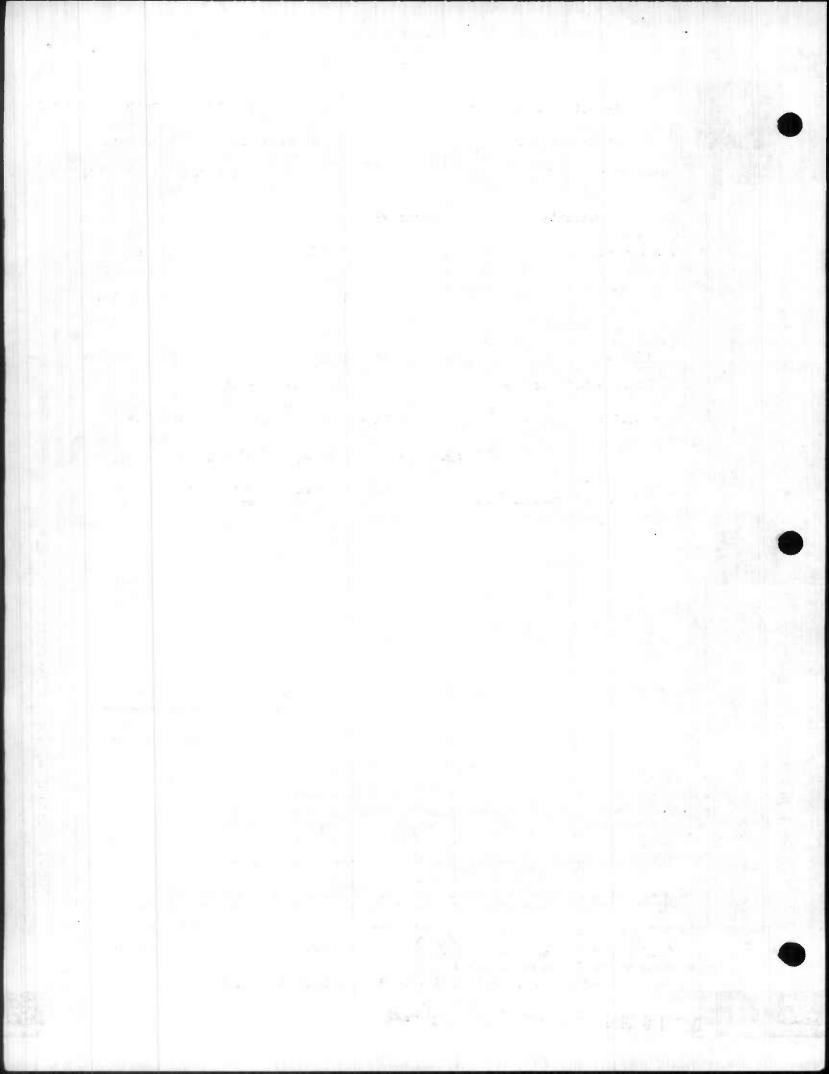
Medical

1 6 2000

31. Date filed (Month, Day, Year)

4 D Homicide

32. Registrar's Signatura



#### Piease Type or Print in Black Indelibie Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Murray Catherine VetaBER 2028 Florence 2000 /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO Hours Min. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year Months Deys 5. Social Security Number Birthplace (State or Foreign Country) 1 M 258 F 178-36-3052 Yrs. Pennsylvania Director Usuet Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Somerset 1 ☐ Yes 259No Westover Directo Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Neck 30041 Revells 218 U.S. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give I Year or Detes: Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Black Specify: 3 □ Widowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondary (0-12) Hygiene. Private tamily Home Domestic 12th Zyrs. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) nd Mental marked or Brown Novada George Washington 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) NeEK Rd, Westover, Md. 21871 Date | 20c. Location - City or Town, State Revells William Murray - Husband Health Hem 27 3004 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition ъ 1 SP Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 10/7/00 Phoenixville, Pa. Morris Cemetery 21. Signeture of Funerel Service Licensee 22. Name end Address of Facility Anthony & Ward Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory afrest, Approximate Approximate **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Box 68760 Physician/Medical that initieted events resulting in death) Last Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records,

Completed 25. Wes cese referred to medical

Be

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ORENCE

To the Hospital or Al within 24 hours after To the Funeral Direc hours after

Registrar

**DHMH 16 Rev 6/95** 

31. Date filed (Month, Day, Year) 0 4 2000

1□ Yes

Naturel

3 Suicide

29e. Certifier (Check anily one)

2 Accident

4 Homicide

5 Pending investigation

6 Could not be determined

29b. Signature and title of pertities

28a. Dete of Injury (Month, Dey Year)

32. Registrer's Signeture

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of tnjury - At home, ferm, street, fectory, office building, etc. (Specify)

**ORIGINAL** 

24b. Were eutopsy findings eveilable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

24a. Wes en autopsy

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Plece of Deeth (Check only one)

28c. tnjury at Work?

Critifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, dete end plece, and due to the ceuse(s) end menner steted.

29c. License number

1 Yes 2 No

1 ☐ Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 00 32606

December 1 Annual Prince   Communication   C								Ce	rtifica	te of	Death			Reg. No.		U	40	00
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Physician Medical Examiner    200	8	20199		Maron	. 1.	do	2060	V									310	
Physician (Acdical Examiner				23a. Part 1. Enter the disease, o	complicati	ons that ca	used the dea	th. Do not en									Approxi	mate
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Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a consequence of):   Sequentially list conditions   Early leading to immediate   Care   Care		•		Immediate Cause (Final		CEN	TEDE DE	TT MONTAR	T7 TYT7	DODE								
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24a. Was an eutopsy performed?  24a. Was an eutopsy performed?  24b. Were autopsy findings eveilable prior to completion of cause of death?  1   Yes   2   No   1   Y	. 6	d by											10	Yes 2	.□ No	3 Prot	bably	Unknow
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26. Place of Death (Check only one)  27. Menner of Death 1 Nonline 28. Detecting the search of the s		pa	Ö										10	Yes 2	₩ No	10	Yes	2□ No
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2 Accident 3 Sulcide 4 Homicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Squature and little of perminer 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)  30. Neme end ed as of person who completed cause of death (Item 23a) (Type, Print)  R. C. TAN, LCDR, MC, USNR  31. Date filled (Month, Day, Year)  32. Registrer's Signeture  3 Squature and Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  29d. Date signed (Month, Day, Year)  30. Neme end ed as of person who completed cause of death (Item 23a) (Type, Print)  NATIONAL NAVAL MEDICAL CENTER  R. C. TAN, LCDR, MC, USNR  31. Date filled (Month, Day, Year)  32. Registrer's Signeture									f	28c. inju	y at		28d. Describe	how inju	ry occurre	ed		1
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29a. Certifier (Check only one) 29b. Signature and little transfer of physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Neme end educes of person who completed cause of death (Item 23a) (Type, Print) 29d. Date signed (Month, Day, Year) 31. Date filled (Month, Day, Year) 32. Registrer's Signeture	2	d in the	ert	4   Homicios		buildin	g, etc. (Speci	ny)					City of To	wii, State	"			
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30. Name and add as of person who completed cause of death (Item 23a) (Type, Print)  R.C.TAN, LCDR, MC, USNR  State  A52356 (CA)  A52356 (CA)  NATIONAL NAVAL MEDICAL CENTER  BETHESDA MD 20889-5600  State	Ho	Ful letely	dic	(Check only 2 Medical	Examiner:	On the bas	sis of examina	ation end/or In	vestigetio	n, in my c	pinlon, de	eth occur	red at the time	dete and	d pleca, a	nd due to	the cau	se(s)
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State of Maryland / Department of Health and Mental Hygiene

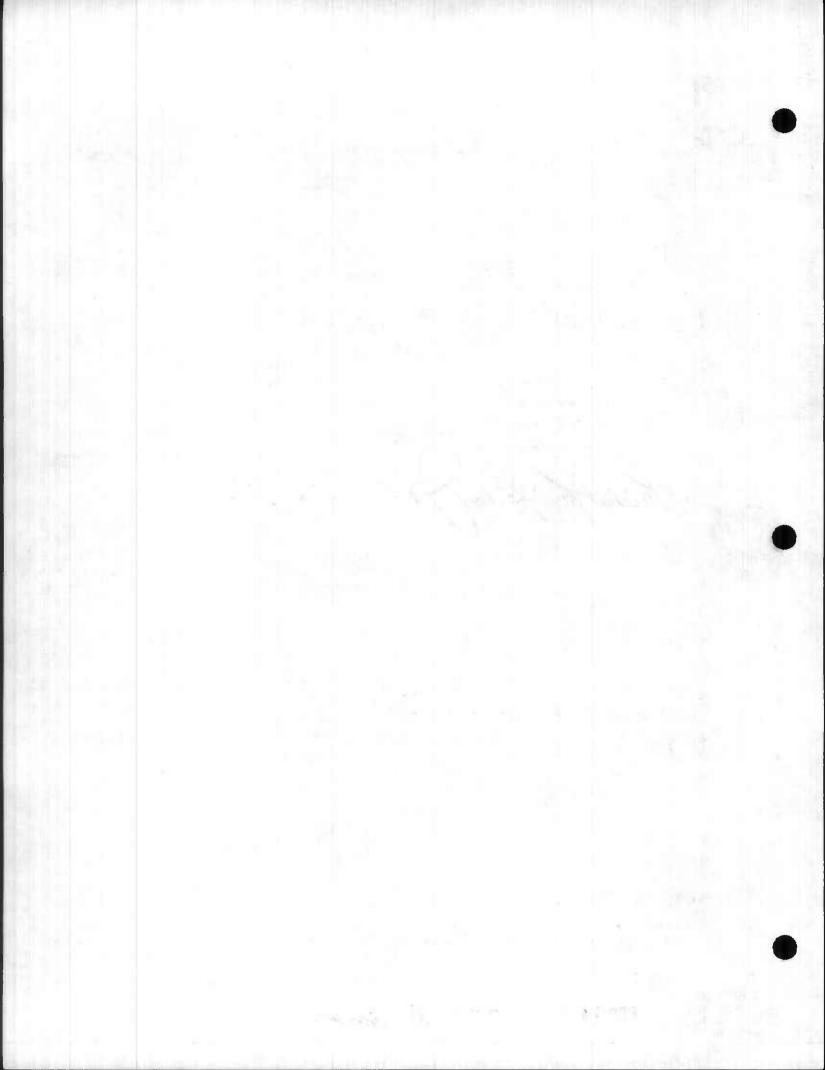
Certificate of Death

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1.5	19a. Informant's	Name/Relations	ship (Ty	rpe, Print)		19b. Mail	ling Address	s (Street	end Numbe	r or Rure	I Routa Nun	bar, City or Tow	n, Stete, Z	ip Code)
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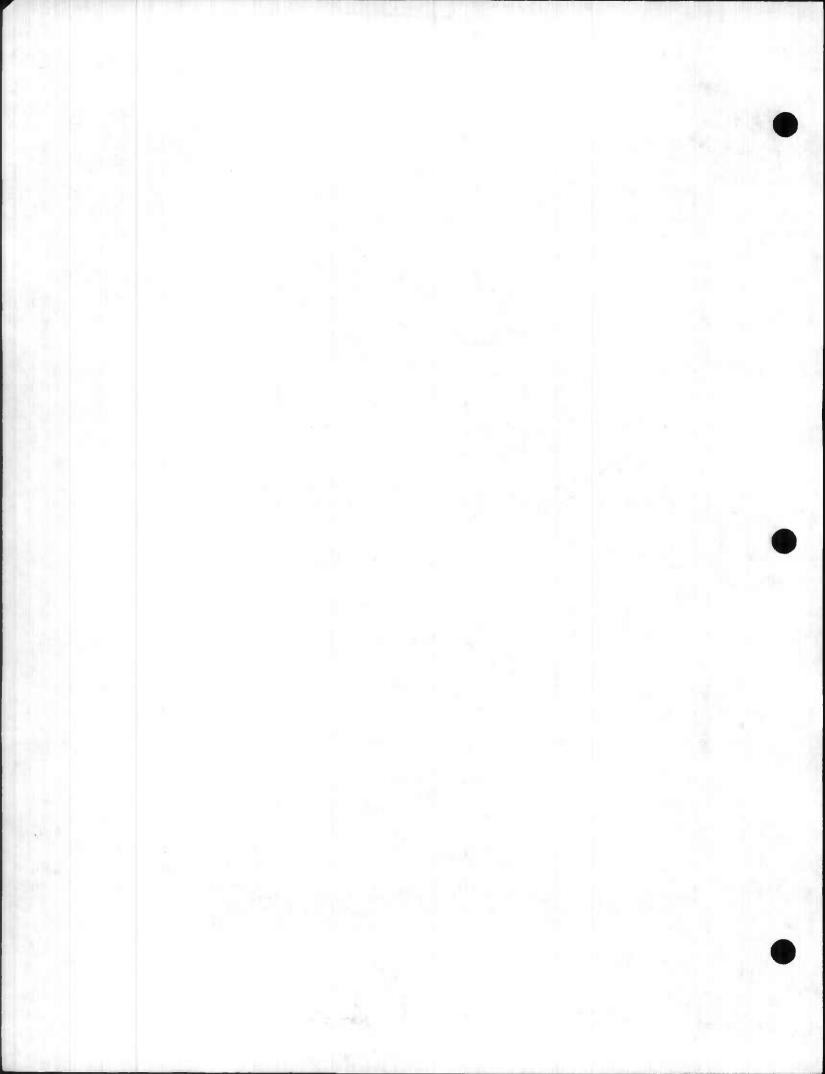
ORIGINAL



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32509

			Certific	ate of	Death		Reg	. No.		02003
ecedent'a Name (First, Middle, Las	st)			8 ,53		2. Date Mont	of Death	Day	Yeer	3. Time of Deeth
Daniel Arthur	McDonnell						embe:		2000	09:52 P.M
aclity Neme (If not institution, give	e street end number)				4b. City, Tow	n, or Location of		4c. County		
Saint N	Mary's Hos	pital			Lec	onardtow	n St. Mary's			
3-84-1460 6. S	ex 7. Ag XM 2□ F	e (In yrs. last 29	birthdey) If Un Yrs. Mont	hs Deys		Min. 8. Dete	of Birth th, Day, Y	Birth 9. Birthplece (State or Fore Country)  3, 1971 Indiana		
el Residence of Decedent										
Stete 10b. County			own or Location						1	Od. Inside City Limits
ryland St. Mar	y's	Leon	nardtown							1 ☐ Yes 2√ No
Street and Number 40441 Breton Vie	ew Drive			Zip Code 20650				U.S.A.		itry?
Meritel Stetus	12. Wes Decedent Armed Forces?	Ever in U,S.	13. Wes De	ecedent ot	Hispenic Origi	in? (Specify Yes Puerto Rican, et	or No-		e - Americ	
Never Married 2 Merried  Widowed 4 Divorced	1 X Yes 2 ☐ If Yes, Give Yeer or Detes:	No			Specify:	r dento rnoan, ot	J.,	Specify		
15. Decedent's Ed (Specify only highest gre	lucation de completed)	1	6a. Decedent'a L	work done	during most	of working	16	b. Kind ot Bu	usiness/Ind	dustry
ementary/Secondery (0-12) 12th	College (1-4or	5+) A	viation		,	lan	Ţ	J.S. N	avy	
ether's Name (First, Middle, Last)					18. Mother	s Name (First, A	liddle, Ma	iden Sumam	ne)	
Robert A. McDoni	nell				Caro	l Ann Sr	niade	cki		
Informent's Neme/Reletionship (	Type, Pnint)	1	19b. Mailing Add	ress (Stree	t and Number	or Rural Route I	Vum <i>ber, C</i>	ity or Town,	Stete, Zip	Code)
rol Ann McDonne	ll (Mother	-)	52399 N	onte	Vista	Drive, (	Grang	er, In	ndian	a 46530
Method of Disposition		20b. Plece	etery, cremetory	(Neme of or other pl	ece)	Dete	20	c. Location -	City or To	wn, State
1 ☐ Buriel 2 ☒ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specifi			art Cren			ce 9/21	/00	Elkha	rt. 1	Indiana
Significane of Funeral Service Ligen	She di	-	22. Name	e end Addr	ess ot Fecility	iner Fur				
Pertil. Enter the disease, or com- shock, or heart failure. List only	Narai	neen	P.O.	Box	270, L	eonardto	own,	Maryla	and 2	0650 Approximete
uentielly list conditions.	b	Due to (or es	s e consequence	of):						
uentielly list conditions, y, leading to immediate is. Enter Underlying se (Disease or Injury initieled events Iting in death) Lest	c	Due to (or es	e consequence	of):						
II. Other algnificant conditions of	ontributing to death b	ut not resultin	ig in the underlyii	ng cause g	iven in Pert I.	230				the cause of death?
							I 🔲 Tes	2 X No	3   10	DEDIY 4 OHKHOWII
						24e	Wes en performe	eutopsy ed?	av	ere autopsy tindings eilable prior to impletion of ceuse death?
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ixaminer?	Hospital:	- 0 13 20	/O	DOA	ther:	ot Deeth (Check			or (Cnee)	b.)
Manner of Death	28a. Dete of Inju	ent 2 TER	b. Time of	28c. Inj		sing Home 5 28d. Des	cribe how	injury occur	red.	of metercyck
□ Naturel 5 □ Pending investigation			Injury M		onk? ]Yes 2.⊠(N			as open		
S Suicide 6 □ Could not be	e 28e. Place of Inj	ury - At home	, tarm, street, fac	ctory, office		004 1	1: no / 104	man and Alexand	han an Dune	a Car
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	and menner st	e.ec.		29c, Licer	ise number		290	I. Date signe	ed (Month	Dev. Year)
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N~				Stree	et, Bal	timore.	Mary	land	21201	
Date tiled (Month, Dey, Year)				0						
Sign	gneture and title of certifier  Styld A  ne and address of person who  ephen S, R	and menner st an	and menner steted.  Include and title of certifier  ALAMA VLACE  The and eddress of person who completed cause of deeth Mem 23  The billed (Month, Dey, Year)  32. Registrer's Signeture	and menner steted.  Include and title of certifier  A Vacily M. P.  The and eduress of person who completed cause of deeth (Mem 23e) (Type, Print)  The hen S. Radentz, 111 Penn  To tiled (Month, Dey, Year)  32. Registrer's Signeture	and menner steted.  29c. Licer  ALGAM A VLACIE, M, P.  10e and eddress of person who completed cause of deeth (Mem 23e) (Type, Print)  111 Penn Street  116d (Month, Dey, Year)  32. Registrer's Signeture	and menner steted.  29c. License number  29c. Licen	and menner steted.  29c. License number  29c. License number	and menner steted.  gneture end title of certifier  29c. License number  29c. License number	and menner steted.  Include and title of certifier  29c. License number  29d. Date signer  29d. Date signer  29c. License number  29d. Date signer  29d. Dat	and menner steted.  Include and title of certifier  29c. License number  29d. Date signed (Month, Dev. Print)  29d. Date signed (Month, Dev. Print)



#### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 32610 Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day Month Year 9:40 a.m. Hope Milford September 6, 2000 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 37285 River Springs Road Avenue Mary's If Under 1 Year if Under 24 Hrs. 7. Age (In yrs. lest birthday) 6. Sex 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) Min. Months 1 M 2 F Days Hours 579-30-6607 Dec. 29, 1917 Maryland Usuel Rasidenca of Decedent 10d. inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No St. Mary's Avenue 10f. Zip Code 10g. Citizan of What Country? 37285 River Springs Road 20609 United States 14. Rece - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 PNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Beautician Beauty Salon 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumeme) Stephen Lawrence Vallandingham, Sr. Julia Marie Bowles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 37285 River Springs Road, Avenue, Maryland 20609 Billy G. Milford / Husband 20b. Place of Disposition (Neme of cemetery, crematory or other plece) Deta 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State 9-11-00 Clements, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Vallandingham Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of Fecility Brinsfield Funeral Home, P.A. Brins M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only ona causa on each lina. neprovescular Arrecen

**Physician** /Medical Examiner

certificate be executed

Division of Vital Records, P.O. Box 68760,

Attending death.

To the Hospital within 24 hours To the Funeral (

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completely

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Department in important: If any injury or pace.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

7 is merical other than "natural", or frame 23a or 28a-f show traumetic avant, the Medical E.a. street must be notified at

nit. Peges 1 end 2 should be filled within 72 hours efter sarment of Health and Mental Hyglene. ortant: If Item 27 is marked other than "natural; or its injury or other thaumatic avent, the Medical Examine.

Maryland 21215-0020

Baltimore.

the Maryland

Dorothy

5. Social Security Number

10a. State

Maryland

11. Marital Status

12

20e. Method of Disposition

Immediate Ceuse (Final diseasa or condition

10e. Street and Number

Directo

Funeral

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Completed

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Examiner physician and s the buriel-transit Physician/Medical 88 esm lo ed by the e signed by t þ Completed hes page 2 director. Be 2 this funeral Certification: Affer or Attend efter death Director:

rasulting in death)	а	Dua to (c	24a. Was an autopsy performed?  24b. War autopsy performed?  1 Yes 2 No 1 Yes 2  26. Place of Death (Check only one)  26. Place of Death (Check only one)  27				
	<b>a</b> b						
Saquantially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (d	or as e consequanc	e of):			
Causa (Disaasa or Injury that initiated evants resulting in death) Last	c	Due to (d	or as a consequence	a of):	. 10		
	d					-	
Part II. Other significant condition	ons contribution	ng to death but not res	sulting in the underly	ying caus	se given in Part I.		STATE OF THE PARTY
						performed?	
25. Was case referred to medica					26 Blood of De		1 Yes 2 No
examiner?	Hospita	li: 1 ☐ Inpalient 2 ☐	ER/Outpatient 3	□ DOA	Other:		Other (Specify)
27. Manner of Deeth  1 Neturel 5 Pendir 2 Accident investi	ng igation	. Dete of Injury (Month, Dey Year)	injury			28d. Dascribe how injury occ	urred
3 Suicide 6 Could 4 Homicide datam	not be nined 286	b. Place of Injury - At h building, etc. (Special	ome, ferm, street, f.	actory, o	ffice	28f. Location (Street end Nur City or Town, Stete)	mber or Rural Route Number,
	Examiner: O						

29c. License number

29d. Date signed (Month, Dey, Year)

Registrar

31. Date filed (Month, Day, Yeer) SEP 1 1 2000

30. Name and address of person who completed cause of death (Itam 23e) (Type, Print)

David C. Allen, M.D., 22815 Washington Street, Leonardtown, Maryland 20650 32. pagistrar's Signature

# crn Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Stephen Frances Madjeski State of Maryland / Department of Health and Mental Hygiene

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	0 1

			Ce	ertificate of	Death	Re	g. No.	0 32611
Dhuaisian	1. Decedent's Neme (First, Middle, La	st)				2. Date of Deeth Month		3. Time of Death
Physician /Medical Examiner	Stephen Francis 4e Facility Neme (#f not institution, give				4b. City, Town, or Lo	August	29, 200 4c. County o	0 1:12 A.M.
LAMINITE	15031 Point Look	cout Road			St. Inigo	es	St. Ma	rv's
Funeral Director	219-76-3023	ex 7. Age (fn y	rs. last birthdaj Yrs.	y) If Under 1 Year Months Deys	r If Under 24 Hrs.	8. Dete of Birth (Month, Dey, April 2	Year)	Birthplace (State or Foreign Country)
*	Usual Residence of Decedent  10a. Stete 10b. County	10c.	City, Town or I	Location				10d. Inside City Limits
ust be notified at rai Director	Maryland St. Mar		St. Ini					1 ☐ Yes 2 No
at be notified al Director	10e. Street and Number 48186 Jutland Far	m Lane		10f. Zip Code 20	684	10	og. Citizen of Wi United	nat Country? States
by Fune	11. Meritel Stetus  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces?  1 Yes 2 No 1 it Yes, Give Yeer or Detes: 1	980 984	8. Wes Decedent of It Yes, specify Cui 1 ☐ Yes 2 1 No	Hispenic Origin? (Sp ben, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American Indien, White, etc. White
Completed	15. Decedent's Ec		16a. Dec	edent's Usuel Occu	upation a during most of work ad)	ing 1	6b. Kind of Bus	iness/Industry
mpl	Elementary/Secondary (0-12)	College (1-4or 5+)				300	Tr. 1. 4	
	12 17. Father's Name (First, Middle, Last)		Chart	er Boat	18. Mother's Name	First Middle M	Fishi	<u> </u>
Be	Henry Robert Madj				Elizabet			
10	19e. Informent's Neme/Reletionship		10h Mai	ilina Addraes (Strae	et and Number or Run			
	Elizabeth Madjeski	**						Maryland 2068
	20e. Method of Disposition		b. Place of Disp	position (Neme of remetory or other p	909)	Dete 2	20c. Location - C	tity or Town, State
	1 ☐ Buriel 2 de Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify		rinsfie	eld-Echol	rematory	0-1-00	Charlott	e Hall, MD
#200 #200	21. Signature 37-uneral Service Use	MO MO	0052	22. Name end Add	ress of Fecility	1 Home.	P.A. 2	2955 Hollywood
	23a. Pert1. Enter the disease, or com shock, or heert tailure. List only	plicetions thet caused the d	eath. Do not e	Road, L	eonardtown	of respiratory erre	50 st,	Approximete
n I	shock, or heert tailure. List only	one cause on each line.	. (					Intervel Between Onset and Death
al	Immediate Cause (Final disease or condition	MA	1+10	20	I in ici	233		
er	resulting in deeth)	a. Due to	o (or es e cons	equence of):	Trilo	010		
je je					9			
edical Examiner	Sequentially list conditions,	Due to	o (or es e cons	equence ot):				
	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	c						
edical	that initieted events resulting in death) Last	Due to	o (or as e conse	equence ot):				
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icla	Pert II. Other eignificant conditions o	potributing to death but not	resulting in the	underlying cause o	iven in Part I	23b. Did to	bacco usa cefi	ribute to the cause of death?
Physician/M		The state of the s		and a second	,	1 U Ye		3 Probably 4 Unknown
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8						24a. Wes en		24b. Were eutopsy findings eveilable prior to
Completed								completion of cause of death?
FOC						1 🗆 Ye	s 2 No	1  Yes 2 No
Be	25. Wes case reterred to medical				26. Plece of Deet	h (Check only on	9)	
To	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2	□ ER/Outpati	ient 3 DOA	ther: 4 Nursing Ho	ome 5 Reside	nce 6 Gothe	(Specify) at scene
	27. Manner of Death 1 □ Neturel 5 □ Pending	28a. Date of injury Month, Day Year	28b. Time Injury			28d. Describe ho	w injury occurre	
Certification:	2 Accident investigation	0/6/1	005	)	Yes 2 No	Impaci	5 EX	red Objects
Medical Certificat	3 Suicide 6 Could not be determined	286. Place of Injury - A building, etc. (Sp	t home, farm, s polfy)	street, factory, office		281. Location (Sti City or Town		r or Rurel Route Number,
		Street				8+. L	lary's	ounty, Md
edical		ysician: To the best of my niner: On the basis of exame end menner steted.						
Me S	29b. Signeture end little of certifier	end menner steted.	^	29c. Lice	nse number	29	9d. Date signed	(Month, Dey, Year)
	NO PITTO	. a. A.	N		C.M.E.		ugust 3	
	> una	, , , ,	レ、		· · · · · · · · · · · · · · · · · · ·	A	agust 3	0, 2000
	30. Name and eddress of person who	completed cause of deeth (						
0	Joseph	1-3 10000		Penn Str	et, Balti	more, Ma	ryland	21201
State	31. Dete filed (Month, Dey, Year)	32. Registrer's Si	grieture	9. Soa	,			
egistrar	SEPUIZ	UUU	6	1. Ana	Kal			



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 32612 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death **Physician** sept. GERALDINE DOLORES NASH 28° 2000 11:32 a.m. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County General Hospital Westminster Carroll County If Under 1 Year If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 8. Deta of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 200 F Director 213-26-6386 Jan. 16 1930 Maryland 70 Usual Residence of Decedant 10b. County Carroll County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at 10d. Inside City Limits Maryland Westminster 1 Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2159 Mayberry Road 21158 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Biack, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? 11 Marital Status 72 hours after 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2 ▼No If Yas, Giva 1 ☐ Yes 2 No Specify: Specify: white Be Completed by 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "na any injury or other traumatic event, the Meas page. Elemantary/Secondary (0-12) Collega (1-4or 5+) homemaker own home 8 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Lyman Cato Howe Mary Ellen McHugh 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) James T. Nash, Sr. / husband 2159 Mayberry Road Westminster, Maryland 21158 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Buriei 2 ☐ Cramation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Oct. 2 St. Joseph's Cemetery Taneytown, Maryland 2000 22. Nama and Address of Facility Skiles Funeral Home 21. Signature of Funaral Service Licensee M01072 136 East Baltimore Street Taneytown, MD 21787 lun 23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilura. List only ona causa on each lina. Approximete Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final 2013 disease or condition rasulting in death) Examiner Examiner ician and burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata ceusa. Enlar Undarlying Cause (Disease or Injury that initiated events rasulting in daath) Lest Dua to (or as a consequence of): physician s the burial Physician/Medical Dua to (or as a consequence of): 980 signed by the atter Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? page 2 1 Yas 2 No certificata 1 ☐ Yas 2 ☐ No or Attending Physician: Be 25. Was cesa rafarred to medicei exeminar? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatiant 2 ■ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Medical Certification: To 1 Yas 2 No After this funeral 27. Mennar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 PNatural 5 Pending invastigation Hospital or Attending
 24 hours after death.
 Funeral Director: After 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be determined 28f. Location (Street and Number or Rurel Routs Number, City or Town, Stata) 3 Suicida 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, deta and place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29e. Cartitiar completely (Check only one)

State Registrar

Mon 31. Data filed (Month, Day, Year) 32. Registrar's Signature OCT 02

30. Nama and addrass of person who completed ceusa of death (Itam 23a) (Type, Print)

25

WBJ

2000

29b. Signatura and titla of certifier

Street

29c, License number

037573

beistersten

29d. Data signed (Month, Day, Year)

MO

5000,85 when 26,2000

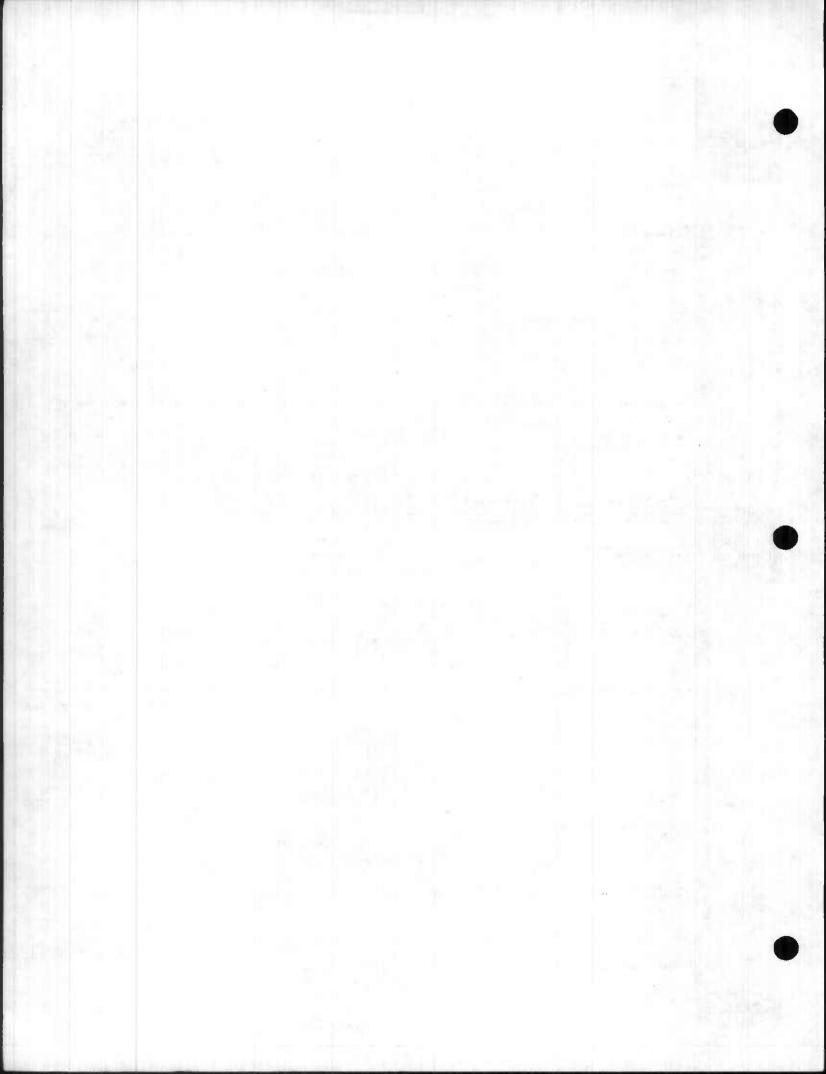
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To the Within 2

Baltimore, Maryland 21215-0020

P.O. Box 68760

Division of Vital Records,

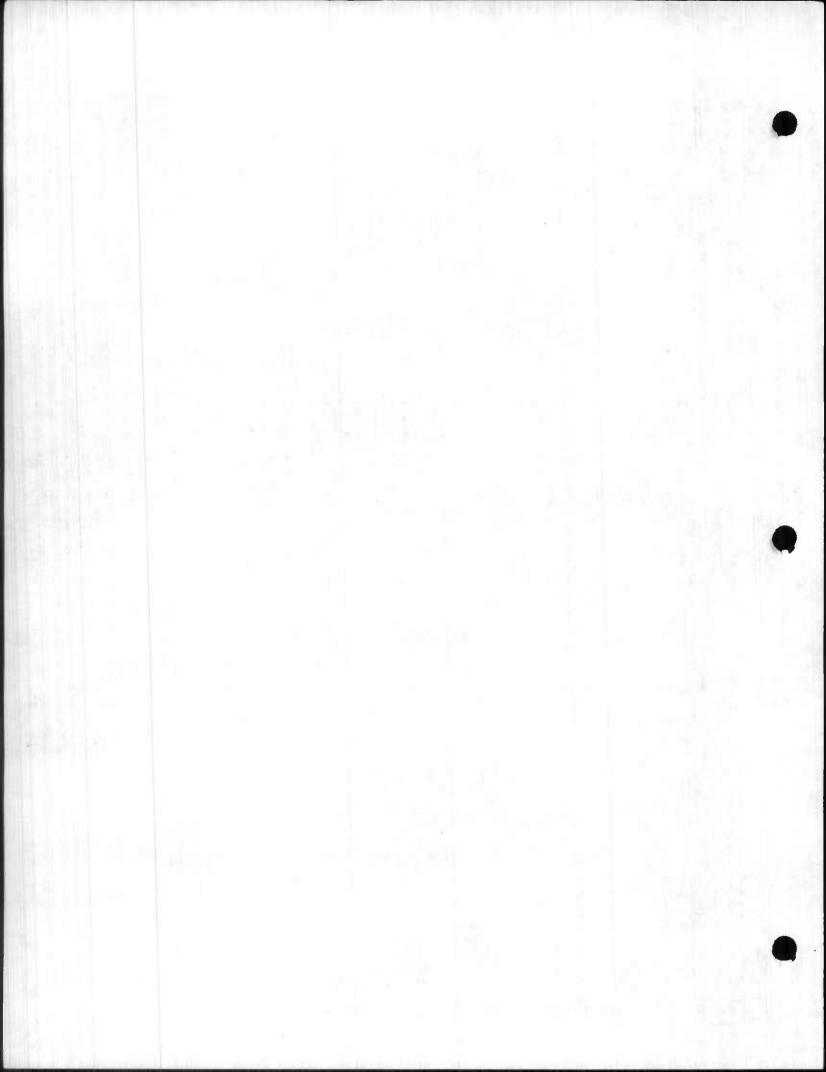


#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32613

				Ce	rtificate	e of	Death			Reg. No.	U	22013	
	1. Decedent's Name (First, Middle	e, Last)							2. Date of De		Vans	3. Time of Death	
Physician (Madisal	ROBERT WARREN	NAY							SEPTEM	BER 22,	2000	5:35AM	
/Medical Examiner	4a Facility Name (If not institution VA MARYLAND HE			EM				wn, or Lo	ocation of Death	4c. County			
Funeral Director	5. Social Security Number 235-30-3818	6. Sex 1 ☑ M 2 ☐ F	7. Age (In)	yrs. last birthday Yrs.	Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Bir (Month, Da Dec. 13	th. Year) 1926	9. Birth	olace (State or Foreign otry) Virginia	
how how	Usual Residence of Decedent 10a. State 10b. County Maryland Hark	ord	10c.	City, Town or L	ill							10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
Ja or 2 at be n	10e. Street and Number 216 Marshall T	rive			101. Zip	050				U.S.A.	What Cou	niry?	
urs after des sr., or lierre Examiner m by Funer	11. Marital Status  1 Never Married 2 Marr  3 Widowed 4 Divorced	Armed I	2 □ No Sive	n U,S. 13.	Waa Deced If Yes, spec		lispanic Ori an, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	14. Rac Bla Specifi	ck, White,	can Indian, elc. ite	
led within 72 ho hygiene. her than "naturn it, the Medical.]	15. Deceden (Specify only higher	st grade completed		16a. Dece (Give life.	edent's Usua e kind of wor DO NOT us	l Occup k done e retire	eation during most d)	t of worki	ing	16b. Kind of B	usiness/In	dustry	
Man Do	Elementary/Secondary (0-12) 8th grade		(1-4or 5+)		e Work					Steel		stry	
Mental H mrked oth rife even To Be	17. Father's Name (First, Middle, Ralph Maxwell	Last)						dys 1		Maiden Suman	ne)		
nd 2 should be file th and Mantal Hy 27 is marked oth 7 traumatic event	19a. Informant's Name/Relations James M. Nay (									er, City or Town,			
semil. Pages 1 ar appartment of Hea mportant: if Item; iny Injury or other alice.	20a. Method of Disposition  1 🖾 Burial 2 🗆 Cremation  4 🗆 Donation 5 🗀 Other (S	3 Removal from		b. Place of Disp cometery, cre	osition (Nan matory or o	e of ther pla	ce)		Date	20c. Location	City or To		
Departm Departm Importar any Inju	21. Signature of Funeral Service		0							Bel Ai l Air,			
death certificate be associated for use as the burial-transit of for use as the burial-transit sician/Medical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	LEF	T BASI	L PNEUMO o (or as a conse RACT INI o (or as a conse o (or as a conse	ONIA quence of): FECTIC quence of):							Approximate interval Between Onset and Death  2 WEEKS  2 WEEKS	
0 0 0	PROSTATE CANCER, STATUS POST PROSTATECTOMY										23b. Did tobacco use contribute to the cause of 1 Yes 2 No 3 Probably 4 Ur		
aw requires ts been sign 2 should be									24a. Was	an autopsy med?	81	ere autopsy findings railable prior to empletion of cause death?	
n: The law licate has t							-134		10		11	☐ Yes 2☐ No	
Physician: this certific ral director, TO Be (	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Hospital:	74	- C - D (0 )		Oth	or.		(Check only o		- 40		
To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	27. Manner of Death  1 25 Natural 5 Pendin 2 Accident investig	28a. Date (Mo	Inpatient 2 e of Injury onth, Day Year	2 ER/Outpatie 28b. Time of Injury		Bc. Injui Wo	4 L2L NU	1		dence 6 Ott		(y)	
Living of Attending Physician: The law requires the after death.  at after death.  at Director: After this certificate has been signed in by the funeral director, page 2 should be defined by Certification: To Be Completed by	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Loc									Street and Numi vn, State)	ber or Run	al Route Number,	
he Hospital in 24 hours he Funeral pletshy filled edical Co		g Physician: To the Examiner: On the and ma											
To the comple	29b. Signature and little of certifier 29c. License number									29d. Date signe	d (Month,	Day, Year)	
1041	30. Name and address of person	who completed cau	use of death (I	Item 23a) (Type		D19	402			SEPTE	MBER	22, 2000	
	SUKH AUJLA, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902										21902		
State Registrar	31. Date filed (Month, Day, Year) SEP 2 6		Registrar's Si		10	31.20	5/						

DHMH 16 Rev 6/95



#### Nursing HauseDe Grace Harford itizens Hone If Under 1 Year 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Devs 1 M 20F Yrs. 213-46-3647 79 Mar. 20, 1921 Germany Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location Director MD Harford Aberdeen 288-1 the Medical Examiner must be notif 10e. Street and Number 10f. Zio Code 10a. Citizen of Whet Country? Berns 23s or 1015 Warwick Drive Apt. 2-D 21001 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 Yes 2000 If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☑ Married 8 Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Homemaker In home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 8 h and Mental P 8 permit. Pages 1 and 2 should to Department of Health and Ment important: if item 27 is marked 2 Franz Thorwesten UNK 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Streat and Number or Rurel Route Number, City or Town, Stete, Zip Code) Edward A. Nordell (Spouse 1015 Warwick Drive, Apt. 2-D, Aberdeen, MD 21001 Saltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Arlington National Cemetery 10/2/00 10 Arlington, Virginia 21. Signeture of Funerel Service Licenses 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or es a consequence of) Examiner physician and s the burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or as e consequença of) 88 950 for signed by the a Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? P.O. 1 Yea 2 No 3 Probably 4 Unknown À 24b. Were autopsy findings aveilable prior to Of Suhration Completed 24e. Wes en autopsy performed?

1. Decedent's Neme (First, Middle, Last)

Gertrude A. Nordell

4e Fecility Neme (If not institution, give streat end number)

Physician

/Medical

Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

September 25, 2006
4b. City, Town, or Location of Death 4c. County of Deeth

3. Tima of Death

7:01 AM

10d. inside City Limits 1 Yes 2 No

Approximete Intervel Between Onset end Death

completion of cause of death?

2 X No

28f. Location (Streat end Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Pay, Year)

26. Place of Deeth (Check only one)

Other: Surring Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

NO

Yeer

4c. County of Deeth

ertend Records, of Vital Nordelly

10

**DHMH 16 Ray 6/95** 

has

funeral

After

r death.

after death Director:

To the Hospital within 24 hours a To the Funeral I Hospital

Be

10

Certification:

edicai

25. Wes case referred to medical examiner?

29b. Signeture and title of certified

1 Yes 2 No

27. Menner of Deeth Neturel

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 | Homicide

State Registrar 30. Neme and eddress of parson who completed cause of deeth (Item 23a) (Type, Print) T. hionpo

Hospitel:

5 Pending Investigation

6 ☐ Could not be

28a. Dete of Injury (Month, Day Year)

31. Dete filed (Month, Day, Year) SEP 2 6 2000

KLESU

32. Registrer's Signeture

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

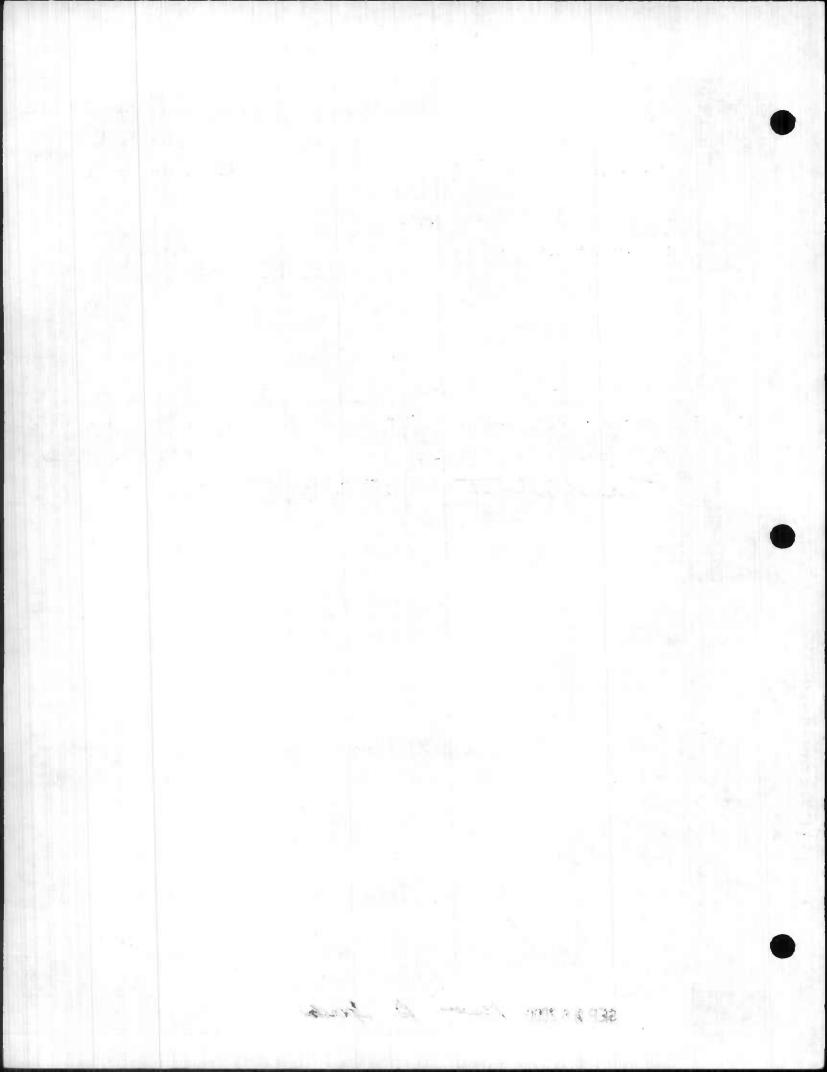
28b. Tima of

28c. Injury et Work?

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

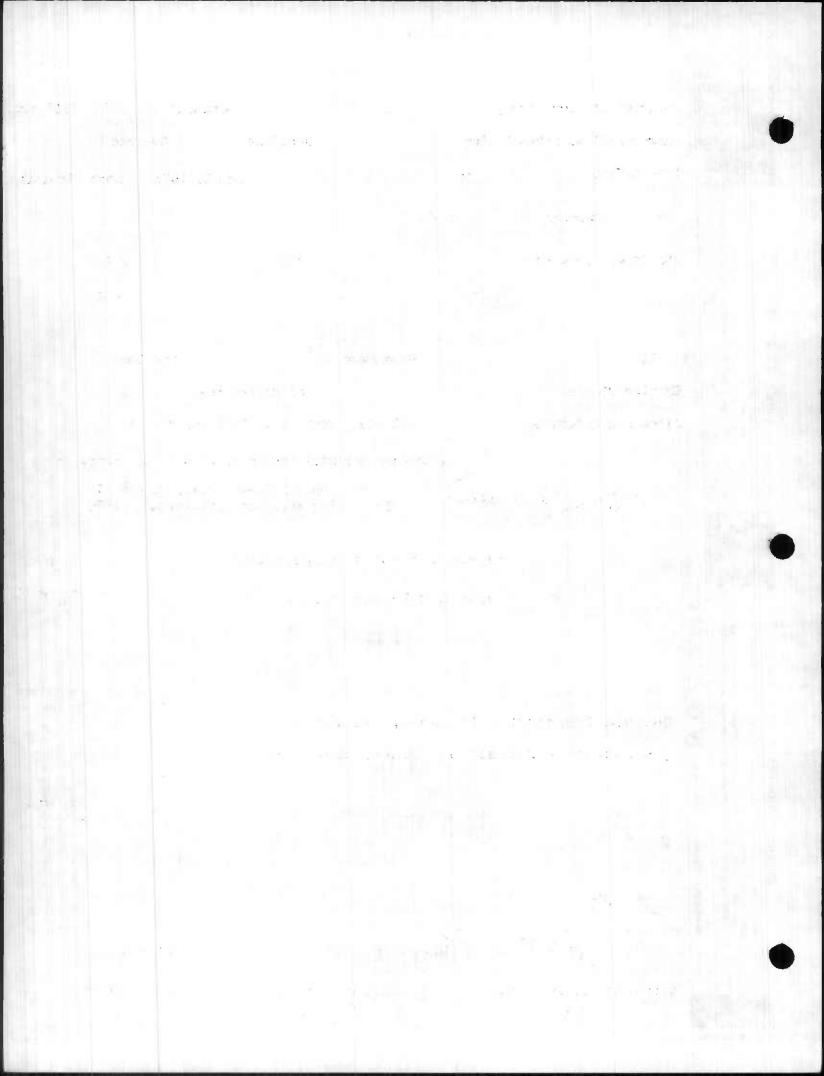
1 Yes 2 No



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 3 2 6 Certificate of Death

				,	Certif	icate of	Death	F	leg. No.	02010					
		Nama (First, Middla	Last)		- 5			2. Data of Dea Month		3. Tima of Death					
Physicia /Medica	- Mar Oar	et O'Brie	n Nicely						ber 23,						
Examine	4a Facility Na		give street end number				4b. City, Town, or	Location of Death	4c. County	ot Death					
	_		isted Livin	g			Acciden		Garre	ett					
Funeral Director	5. Social Section 226–26	6666	1□ M 2  F	ge (In yrs. last i		Undar 1 Yaar lonths Days		8. Date of Birtl (Month, De)	, Year)	9. Birthplace (State or Foreign Country)  West Virginia					
pue *	Usual Reside	nce of Decedent 10b. County		10c. City, To	own or Locati	on				10d. Inside City Limits					
e Maryli	MD 10e. Street an	Garre	tt	Oakla						1 ☐ Yes 2 ☑ No					
1 2 2 E	10e. Street ar	nd Number				10f. Zip Code			l0g. Citizen of W	/hat Country?					
ath w		owy Creek					21550			USA					
urs a	3 ₩ Widow	atus Marriad 2 Marri wed 4 Divorced	12. Was Deceden Armed Forces at I Yas 2 X If Yes, Give Yaar or Dates:	?		S Decedent of less, specify Cub	Hispanic Origin? (Sean, Mexican, Puerl Specify:	pacify Yas or No- lo Rican, atc.)		e-American Indian, k, White, etc. : white					
Maryland 21215-0020 d 2 should be filed within 72 hours af th and Mental Hygene. 7 is marked other than "natural", or treumatic event, the Medical Exer-	Elementary	15. Decedent (Specify only highas /Secondary (0-12)			(Give kind life. DO	NOT use retire	during most of wor	rking	16b. Kind of Business/Industry						
d 212 filed with Hygiene. ther than		lama (First, Middle, L	ast)		Homema	aker	18. Mother's Nar	Own Home							
Maryland 212: d 2 should be filed within th and Mental Hygiene. 7 is marked other than treumatic event, the Mental Hygiene.	n	s O'Brien						200							
laryla 2 should land Menidian merke	_	nt's Name/Relationsh	ip (Type, Print)	1	9b. Mailing A	Address (Stree	t end Number or Ru	Hannifan ure/Route Numbe	r, City or Town,	Stete, Zip Code)					
and 2 saith ar n 27 is		Alice Evans/daughter 581 Snowy Creek Rd., Oakland, MD 215													
s 1 and if Health Item 27 other tr	20a. Method	20a. Method of Disposition 20b. Place of Disposition (Neme of Competent of State Place)													
				1				Sept 26	OO Low	Moor, VA					
Baltimore, pemit. Pages 1 a Department of Her Important: If item into Injury or othe		Alleghany Memorial Park Sept 26,00 Low Moor, VA  21. Signatura of Funeral Service Licensea  22. Name and Address of Facility  Neuman Funeral Homes. P. A. PO Boy 275													
_	179 Miller St., Grantsville, MD 21536  23a. Part I. Enter the disease, or controlled that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Be onset and one cause on each line.														
Physician /Medical Examiner	Immediate Codisease or coresulting in de	ause (Final			e mot	or po	lyneuro			Onset and Death					
6876( ficate be physicia ts the bur	resulting in de		b.—prof( c	Due to (or as	12 consequer	lefici	ency		4	many years					
Box eath cert attendin for use	2		0												
P.O. at the at the etache	Ž C		hocytic					23b. Did t	0/	atribute to the cause of death?  3 Probably 4 Unknown					
Records,	0		for bleed						an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?					
= F # a a	5							101	ea 25 No	1 ☐ Yes 2 ☐ No					
recian: The	25. Was case examiner	reterred to medical	14					ath (Check only o	ne)	Assisted					
this his	0 1 □ Yes	200No	Hospital:		-	3LI DOA	- 0	fome 5 Resid		er (Specify) Living					
ding P. After funer	27. Manner of	al 5 Pending		ay Yeer) 281	b. Time of Injury	28c. Inju		28d. Describe r	ow Injury occurr	90					
Division of Attending after death. I Director: After d in by the fune	27. Manner of	de 6 Could n	ot be gen Place of Is	njury - At home vic. (Specify)	, tarm, street		Yes 2 No	28f. Location (3 City or Tov		er or Rural Route Number,					
	29a. Certifier	(Check only 2 Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s)													
To the comp	29b. Signatur	erand title of certifier		1/	\	29c. Licen	se number		29d. Date signed	d (Month, Day, Year)					
- > - 0	1	larger	eta	Plus	nW	D26	650		9/23/	′2000					
10	30. Name and	address of person v	who completed cause of	death (Item 23	a) (Type, Pri	nt)				,					
State		ret Kais (Month, Day, Year)	ser, M.D. 32. Regis	1307 trar's Signature	9 Gar	rett	Highway	; 0ak1a	ind, MI	21550					

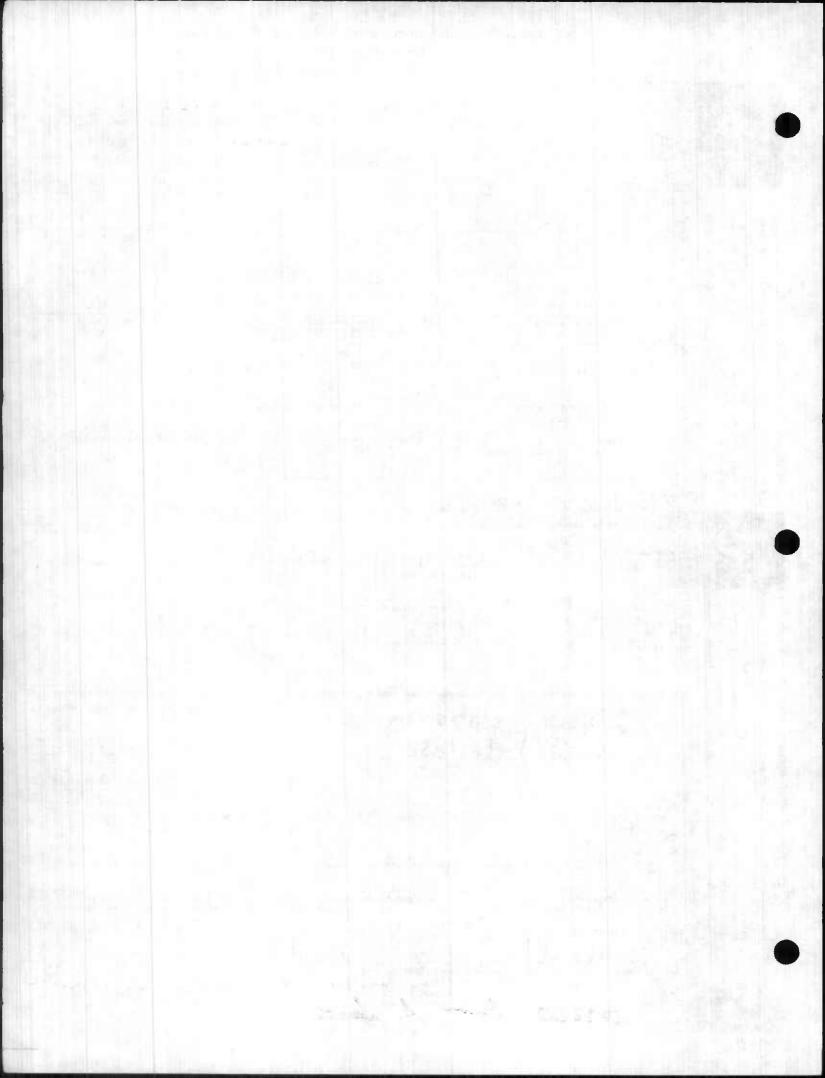
DHMH 16 Rev 6/95



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				State of	Maryland		rtment of F	lealth and N <i>Death</i>		eg. No.	00 32616
	Physicia	an	1. Decedent's Neme (First, Middle, L						2. Dete of Deet Month	h Dey	3. Time of Death
6	/Medic	_	Joseph	Neal		ris, Jr			Septemb		000 13:35
F.	Examin	er	4a Facility Neme (If not institution, g		oer)			4b. City, Town, or L		4c. County	
_			21209 Woodmere D 5. Social Security Number 6.		Age (In yrs. I	ast hirthday)	If Under 1 Yeer	Leonard			. Mary's
	Funeral Director		216-28-1781	1₩ 2□ F	71	Yrs.	Months Deys	Hours Min.	8. Dete of Birth (Month, Dey) January	Year)	9. Birthplace (Stete or Foreign Country)
_			Usuel Residence of Decedenf						Danuary	13,1920	Washington, DC
	nylan how		10a. Stete 10b. County		10c. City	, Town or Loc	cation				10d. Inside City Limits
	Be-f	cto		Mary's	I	eonard	7				1 ☐ Yes 2 ☑ No
	1 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of W	/het Country?
	23a	ie i	21209 Woodmere I	_	Francis III	0 40 14		550		U S	
	hours after death with the Meryland ural', or flems 23s or 28s-f show at Everyland Parad 25	Funeral	11. Meritel Status  1 ☐ Never Merried 2 ☑ Merried	12. Was Decede Armed Force 1  Yes 2	es?	S. 13. V	Yes, specify Cub	lispenic Origin? (Sp en, Mexican, Puerto	Rican, etc.)		a - American Indien, k, White, etc.
020	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dete		1	☐ Yes 21 No	Specify:		Specify:	White
21215-0020	72 hor	ted	15. Decedent's I			16e. Deced	ent's Usuel Occup	nation during most of work	ina	16b. Kind of Bu	siness/Industry
21	filed within 72 Hygiene. ither than "natent, the Medic	Completed	(Specify only highest g Elementery/Secondery (0-12)	College (1-4	or 5+)	life. D	OO NOT use retired	d)	wing		
2	Hygien ther th	Co	12th Grade			Ov	vner/Oper			Retail	
and	Mental H Mental H arked oth	Be	17. Fether's Neme (First, Middle, Las			Cee		18. Mother's Nem			
aryiand	d 2 should be filed within 72 hours after death with the Marylar had Menall Hygiene. I is marked other than "natural", or frema 23a or 28a-f show traumatic event, the Madical Examinational Demotived at	2	Joseph Nea  19e, Informant's Neme/Reletionship		orris,		a Address (Street	EVa end Number or Rus	Sede		Mayor State Zin Codel
-	d the training of the training		Elizabeth A. Nor		ise)						aryland 20650
o o	the other		20e. Method of Disposition		20b. PI	ece of Dispos	sition (Name of				City or Town, Stete
more,	Pages nent of int: If he iny or o		1 ☑ Buriel 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spec		ate		s Catholic		9/12/2000	Valley I	ee, Maryland
	parmit. Pages Department of Important: If I any Injury or DRGs.		21. Signature of Funerel Service Lice		0	22.	Neme end Addre	ss of Fecility			
m	a de la la		Muchaels	Dand	mier			7-Gardine			
			23e. Pert1. Enter the disease, or conshock or heert lailure. List onl	mplications that cause on each	used the deeth	. Do not ente	or the mode of dyli	ng, such es cardiac	or respiretory err	_Maryla	Approximate interval Batween
	Physician	Н	STOCK OF HOUR TAILORS. ELSE OF	y one occase on eec	O 1		0				Onset end Death
	/Medical Examiner		Immediate Cause (Finel disease or condition	A	Cole	on	Carci	roma			3465
	Examine	-	resulting in deeth)	-	Due to (or	es a consequ	,				
	nsit n	Examiner		b	Mint.						
	cate be assecuted physician and sthe burial-transit	Exar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events		Due to (or	es e consequ	uence of):				1
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O. E	0 %	sici	Part II. Other significant conditions	contributing to deat	th but not resu	ilting in the un	derlying cause giv	ven in Pert I.	23b. Did to	obacco uee cor	ntribute to the cause of death?
<u>P</u>	iaw requires that the de as been signed by the s 2 should be detached		Bili	176 0	Lite	ichh	<b>S</b>		1 🗆 Y	00 2 No	3 Probably 4 Unknown
ds,	signe d be d	1 by			١	, 0,			24e. Wes e	l autonou	24b. Were autopsy findings
Records,	peen	Completed	Live	( me	us to	rses			perfor		available prior to completion of cause
Rec	has has	mp								×6	ot death?
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5	Physician: r this certifice and director, p	To B	examiner?	Hospitel:	patient 2 1	EB/Outpetient	Ott	26. Plece of Dee	ome 5 Reside		or (Snacity)
0	Phy eral o		27. Manner of Deeth	28e. Dete of	Injury	28b. Time of	28c. Inju		28d. Describe h		
Division	Attending For death.  Sector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigeti		Day Year)	Injury		Yes 2□No			ALC: YELLOW
<u>&gt;</u>		Certification:	3 Suicide 6 Could not determine	d 286. Pieca of	Injury - At ho	me, farm, stre	et, factory, office		28f. Location (S City or Town	treet end Numb n, State)	er or Rurel Route Number,
	ral Old		V								
	To the Hospital within 24 hours a To the Funeral C completely filled	edicai	29a, Certifier 1/2 Certifying P (Check only one) 1/2 Medical Exi	Physician: To the be miner: On the basi end menne	is of examineti	viedge, deeth ion and/or inv	occurred et the til estigation, in my o	me, dete end plece, opinion, deeth occur	end due to the c red et the time, d	ause(s) and me lete end pteca, i	nner as stated. and due to the ceuse(s)
	within To the comple	Med	29b. Signeture and title of certilley	/ n l	steteu.		29c. Licens	se number	2	9d. Date signed	d (Month, Day, Year)
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		-	30. Name end eddress of person who	o completed cause	of deeth (Item	23e) (Type F	Print)			- 111	-100
	DN la		Willian K. Ke	du Mil	- 06	215-	St Mar	ys Hos	, Leon	urdor	m MDZOLSO
	Sta Registr		31. Dete filed (Month, Dey, Year) CFD 12.7	000 32. Re	istrer's Signet	ure 6	done	-			

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day Year SENTEMPHE 28 2000 Physician ,20 PATTERSON BERNICE /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner CARE CENTER BALTO DAKCREST VILLAGE BALTO If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) JUNE 30, 1914 9. Birthplaca (State or Foreign Country) New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 Ø F 079-05-3193 86 Director Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or itema 23s or 28s-f show traumatic event, the Manical Experient must be notified at 1 Vas 2 □ No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 1113 Sunset Drive 21014-2497 U.S. A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Giva Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Statue 14. Race - American Indian, Black, White, atc. 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify. à 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filled wi Department of Health and Mentel Hyglen. Important: If Nem 27 is married other that any Injury or other traumatic aware years Educator Public School System Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Perry Marie Armstrong 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith P. Merow (Daughter) 1113 Sunset Drive. Bel Air. MD 21014-2497 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removel from State 9/29/00 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory Baltimore. Maryland 22. Name and Address of Fecility Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licenses 610 W. MacPhail Road, Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Rans disease or condition resulting in death) Examiner Examiner and Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): ò Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? eut signed by t 3 Probably 4 Ponknown 1 ☐ Yea 2 ☐ No by 24b. Wara autopsy findings evailable prior to completion of causa of death? 24a. Was an autopsy performed? Completed 1 Yas 2000 1 ☐ Yes 2 ☐ No certificate Viital Be 25. Was case referred to medical 26. Place of Seeth (Check only one) Other: 6 Other (Specify) 1 Yas 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA edical Certification: To 27. Manne of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 BNetural 5 Pending death. 1 Yas 2 No investigation 2 Accident Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 ☐ Homicide 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated. (Check only one) pr: Of the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tille of certifier 29c. License number 29d. Data signed (Month, Day, Year) Ydric 00 6 30. Name and address of person who cold d cause of death (Item 23a) (Type, Print) M.S. sielcis 8800 WALTHER BLOD. PARKVICE, MB, 21234 State 2000 Registrar

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State of Maryland / Department of Health and Mental Hygiene

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			Certificate of	of Death	Reg. No.	00 22010							
51 151	1. Decedent's Neme (First, Middle, La	ast)		2.	Data of Death Month Day	3. Time of Death							
Physician /Medical	Minnie	Catherine Per	terson	Oc	ctober 2, 2								
Examiner	4a Fecility Name (If not institution, gir	The state of the s		4b. City, Town, or Locati	on of Death 4c. Co	ounty of Death							
		rial Hospital		Havre de		Harford							
uneral		Sex 7. Aga (in yrs.	last birthday) If Undar 1 Your Months Da		Date of Birth (Month, Dey, Year)	Birthplace (State or Foreign Country)							
rector	170-32-0770	97	TTS.	Ar	oril 13, 19	003Pennsylvania							
	Usual Residence of Decedent  10a, State 10b, County	10c. Cit	y, Town or Location			10d. Inside City Limits							
apa to	MD Harfo		Aberdeen			1 Nas 2 No							
be notified Director	10e. Street and Number	i i	10f. Zip Coo	ia	10g Citize	n of What Country?							
10	308 Paradise Ro	ь	210			S.A.							
mus 9678	11. Maritel Status	12. Was Decedent Evar in U		of Hispanic Origin? (Specify Cuban, Mexican, Puerto Rici		. Race - American Indian,							
Funer	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2√∑ No				Black, Whita, etc.							
by	3€Widowed 4 □ Divorced	If Yes, Give Year or Datas:	1□ Yes 🐒	No Specify:	S	Decily: White							
ted ted	15. Decedent's E	ducation	16a. Decedent's Usuel Oc	ccupation	16b. Kind	of Business/Industry							
t, the Medical	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use re	one during most of working stired)									
100	12	2	Teacher		Educ	cation							
Be	17. Fathar's Neme (First, Middla, Last	1)		18. Mother's Nama (Fi	irst, Middle, Meiden St	umeme)							
To F	Pius A. Noll			Elizabet	th Roth								
- In	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (St	reet end Number or Rurel R	oute Number, City or 1	Fown, Stata, Zip Code)							
1	David N. Peters			Road, Church	ville, Mar	ryland 21028							
6	20a. Method of Disposition		Place of Disposition (Neme of emetery, cremetory or other	plece)	Date 20c. Loca	ition - City or Town, Stata							
0	1 Burial 2 ☐ Cremation 3 4 ☐ Donetion 5 ☐ Other (Speci		y Saviour Cem	etery 10/	/5/00 Beth]	ehem. PA							
重	21. Signatura of Funeral Sarvice Lice			dress of Facility Cargo Funeral	Heme D ?								
28	* Kirsen IV	RILLIMIES		, Maryland 2		1.							
-	23a. Part1. Enter the diseasa, or con shock, or heart failure. List only	nplications that caused the deat	h. Do not enter the mode of	dying, such as cardiac or re	spiratory arrest,	Approximate Interval Between							
ian	SHOOK, OF HEART TARROTE. CIST ONLY	y one cause on eachine.				Onsat and Death							
ical	Immediate Cause (Final disease or condition 34444												
ner	resulting in deeth)	disease or condition											
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Examiner	Sequentielly list conditions,	b. Due to (c	r as a consequence of):										
	Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Disease or Injury					1							
2 2	that initiated events resulting in death) Last	Due to (o	r es a consequence of):										
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for us													
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d be d					24a. Was an autops	. 24h Were autopsy lindings							
should					performed?	evailable prior to completion of causa							
page 2 should				•		of deeth?							
S					1 □ Yes 2 □	No 1 Yes 2 No							
director.	25. Was case referred to medical examiner?	142-1		26. Place of Death (C	check only one)								
7	1 ☐ Yes 2 ☐ 1√10		ER/Outpatient 3 DOA		5 Residence 8								
funera lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Dete of Injury (Month, Dey Year)		Work?	I. Describe how injury	occurred							
cat	2 Accident investigation 3 Suicide 6 Could not to	he	ome, farm, street, factory, of	1 Yes 2 No	1	N = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 =							
Certification:	4 Homicide determined	Number or Rural Route Number,											
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edical	(Check only 2 Medical Exa	hysician: To the best of my kno miner: On the basis of examine	wledge, deeth occurred at the tion end/or investigation, in the tion end/or investigation, in the tion end/or investigation, in the tion end/or investigation.	e time, date and place, and my opinion, death occurred	due to the ceuse(s) e at the time, date end p	nd menner es steted. lace, end due to the cause(s)							
completely filled in by Medical Certifi	one)	and manner stated.	29c 1ii	cense number	29d Date	signed (Month, Dey, Year)							
0	29b. Signature and title of confidence	- (118	7 / 7 ( >		1								
Ö	1 1 1/1/1			21/12	101	3/60							
ō	Con	- 0 - 0											
Comple	30. Name and address of person who	completed cause of death (Iter	n 23a) (Type, Rrint)	F ALP TO	VECT !	141) 2 AU							
,	30. Name and address of person who	completed cause of death (iter  70 29 W Bt  37 Registrar's Signs	elack Acc	E ABECLO	EEU, 1	MD 21001							

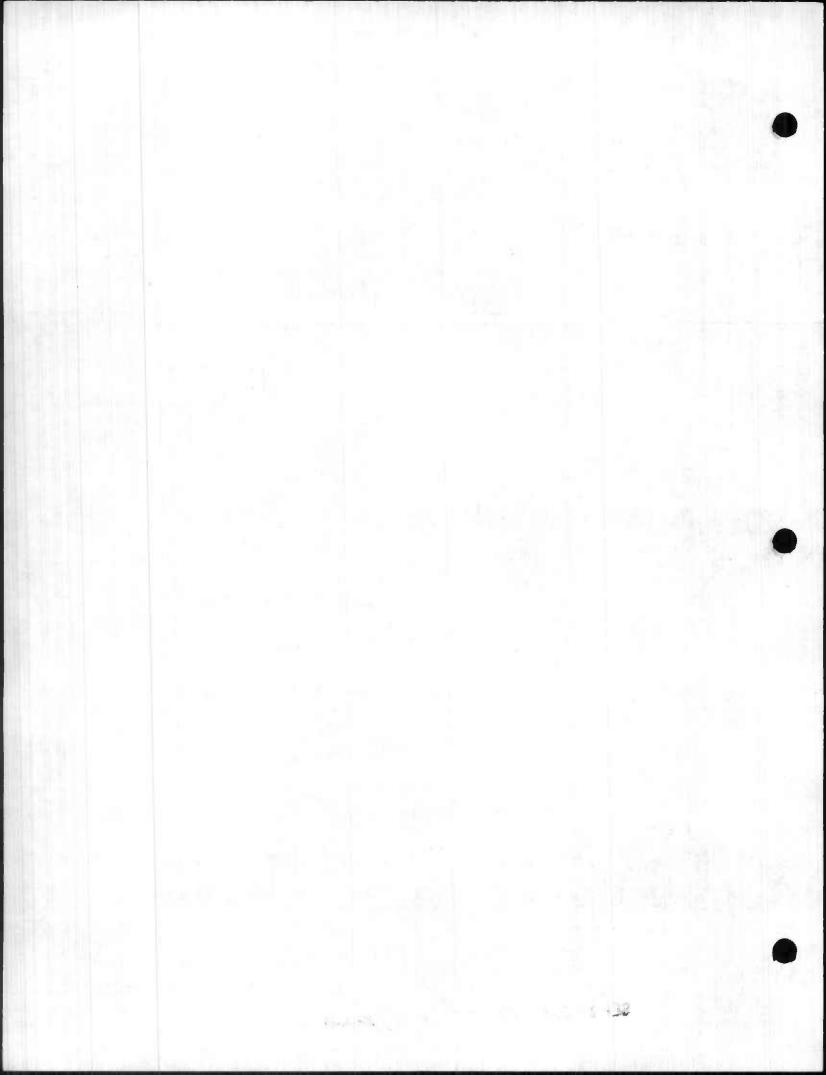
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			Certificate	of Death	Я	eg. No.	3 32	619
<b>5</b> 1 .1.1.	1. Decedent's Neme (First, Middle, Last				2. Dete of Deal Month	th Dey	Year 3. 1	Time of Death
Physician /Medical	Salvatore	Pinelli	Barrier Li			BER 21,		12:10AM
Examiner	4e Facility Neme (If not institution, give			4b. City, Town, or I		4c. County	of Deeth	
	VA MARYLAND HEALT		MIladas 1	PERRY P		CEC		
Funeral Director	070 03 0004	X 7. Age (In yrs. la 7 7 8	Yrs. If Under 1 Y Months D	ays Hours Min.	8. Dete of Birth (Month, Day, June 10	, 1922	9. Birthplace ( Country) New Yo	(State or Foreign ) TR
E.	Usuel Residence of Decedent  10a. Stete 10b. County	10c. City,	, Town or Location				10d. fn	side City Limits
for for	Maryland N/A		Bal	timore			1	Yes 2□No
or 28e-f s be notified Director	10e. Street and Number		10f. Zip Co		1	0g. Citizen of W	Vhat Country?	
at ba	5609 Winthrope A	renue		21214		и	.S.A.	
if, or Here 23s or 24s-1 sho kaminer must be notified at by Furneral Director	11. Maritel Stetus  1 Never Married 2 Merried  3 Widowed 4 Divorced	12. Wes Decedent Ever in U,S Armed Forces? 1 (X) Yes 2 □ No If Yes, Give Yeer or Detes: (WW ] []	S. 13. Was Decedent If Yes, specify 1 ☐ Yes 2 【X	of Hispanic Origin? (S Cuban, Mexican, Puerlo No Specify:	pecify Yes or No- Rican, etc.)		e - American Inc ck, White, etc.	ite
	15. Decedent's Edu	cation	16a. Decedent's Usual O	ccupation		16b. Kind of Bu	usiness/Industry	,
ypere. At the Medical. Completed	(Specify only highest grad	le completed) College (1-4or 5+)		one during most of wor etired)	king		6.	
Con	8th Grade		Mechan			Automo.		
wed off	17. Fether's Neme (First, Middle, Last) Santo Pinelli			18. Mother's Nan France	ne (First, Middle, I S Carri		e)	
artment of Health and Mi ortant: If them 27 is mant injury or other traumati B.	19e. Informent's Neme/Reletionship (7) Mrs. Nancy Twr	(sister)		ide Ct., P				в)
of the H	20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremetion 3 ☐ F	20b. Pla	ace of Disposition (Name of metery, crematory or other	place)	Date	20c. Location -	City or Town, S	State
ment ment in a serie i	4 Donetion 5 Other (Specify)	Gre	en Mount Cre	matory	9/22/00	Baltim	ore, Ma	ryland
Depart Import any in	21. Signeture of Funeral Service Licens	Kelly	22. Name and A Schim 9705	ddress of Facility Unek Funer Belair Rd.	al Home, Baltim	Inc.	21236	
ste has been signed by the attending physician and page 2 should be detached for use as the bunal-transit and page 2 should be Applicated by Physician/Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in death)  Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
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by the at stached for the physic	Part fl. Other eignificant conditions con	tributing to death but not resul	lting in the underlying caus	e given in Part I.	23b. Did to	bacco use cor	tribute to the	cause of death?
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ate has been signed the page 2 should be deticated by P					24a. Wes a perform		aveilable	utopsy findings e prior to tion of cause 1?
page 2					1 🗆 Y	es 2KINo	1 ☐ Yes	2 □ No
s certificate director, pag To Be Co	25. Was case referred to medical examiner?				ith (Check only on	10)		
T di	1 ☐ Yes 2 🛣 No		R/Outpatient 3 DOA		ome 5 Reside			
vr. After the funer	27. Menner of Death  1 X Neturel 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	Injury at Work? 1 Yes 2 No	28d. Describe ho	w Injury occurr	ed	
within 24 hours after death.  To the Funeral Director. After this certific completely filled in by the funeral director,  Medical Certification: To Be is	3 Suicide 6 Could not be 4 Homicide determined	28e. Placa of Injury - At hor building, etc. (Specify)	me, farm, street, factory, of	fice	28f. Location (Si City or Town		per or Rural Rou	ite Number,
within 24 hours after To the Funeral Dir completely filled in		ofcien: To the best of my knowner: On the basis of examination and manner stated.						cause(s)
within comp	29b. Signeture and title obcertifier		29c. Li	cense number	2	9d. Date signer	d (Month, Day,	Year)
	amalhin	m	D	39170		SEPTEN	MBER 21	2000
4+1	30. Neme and address of person who co		23a) (Type, Print)					
1 4.	RAKESH MATHUR, M.	.D., VA MARYLA	ND HEALTH CA	RE SYSTEM,	PERRY PO	INT, MA	RYLAND	21902
State Registrar	31. Date filed (Month, Day, Year) SEP 2 6 200	32/Registrar's Signatu	G. Som					

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DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 00 32620

							Certific	ate of	Death		R	eg. No.	U	32020
			1. Decedent's Neme (First, Middle	, Last)	THE.						2. Date of Dear Month		Year	3. Time of Death
ą.	Physici /Medic		Annabell Pearson	n Pinder							Septemb		2000	12:05p.m.
	Examir		4a Facility Neme (If not institution						4b. City, To	wn, or Lo	cation of Death	4c. County of		
V			113 Charles Str						Sud1			Queen		
*	Funeral Director		5. Social Security Number 220–34–9472	6. Sex 1 ☐ M 2 🂢 F	7. Age (I	In yrs. last birti	frs. If U	nder 1 Year ths Deys	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Dey January 1	5, 1919 1	9. Birthpl Count 31ancc	ece (Stete or Foreign try) Delaware
	and **		Usuat Residence of Decedent  10a. State 10b. County	Te. Un-	10	0c. City, Town	or Location						11	Od. Inside City Limits
	f aho	ō	A CONTRACTOR OF THE CONTRACTOR	n Anne's			ersvil	1.0						1 Yes 2 No
	198 1	rect	10e. Street and Number	I AILE S		Sudite	-	. Zip Code			1	0g. Citizen of W	hat Coun	try?
	death with the Maryland irrs 23e or 28e-f show	Funeral Director	113 Charles Str	eet Ant.	1-R			21668				USA		
	death	Jera	11. Manital Stetus	12. Wes Dec	edent Eve	er in U,S.	13. Was D		lispanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	14. Raca		an Indian,
21215-0020	or its	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed F ed 1 Yes If Yes, G Year or I	2XXVIO			specify Cub			Hican, etc.)		White, white, whi	
2-0	n 72 hours "natural",	Completed	15. Decedent (Specify only highes	's Education	)	16a.	Decedent's	Usual Occup	oation during mos	t of worki	ina	16b. Kind of Bus	iness/Ind	lustry
121	Pie	nple	Etementery/Secondary (0-12)		(1-4or 5+)			f work done of use retire	d)					
	be filed with tel Hyglene, d other that event, tre	CO	8	1 41		Sa	ales C	lerk	40 Marks	de Name	/Final Middle	Retail	-1	
Maryland	2000	Be	17. Father's Name (First, Middle,									Maiden Sumame	")	
2	should be nd Mente marked	70	George W. Pears			106	Mailing Ada	Iraca (Straat			ingswor	th r, City or Town, S	State Zin	Codel
Z Z	d 2 s th en 7 is r		Robert W. Pinder											
	ges 1 and of Heal	77	20a. Method of Disposition	1,2011		20b. Place of	Disposition	(Neme of		ad, r	Dete	n, Mary	Land City or To	21640 wn, State
Baltimore,	2 # g # 7	Ŋ	1 X Burial 2 ☐ Cremation 4 ☐ Donetion 5 ☐ Other (Sp		State	Sudlers		or other pla		10		Sudlersvi		
Ball	permit. Pe Departmer Important: any Injury pncs.		21. Signature of Funeral Service I	0//////	20		F011072	s, Helf	mboin	s No-	mom Planes	1 II	D A	
	9-11		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the	e death. Do n	ot enter the	mode of dyi	ng, such as	cardiac o	or respiratory arr	Maryland	2165	Approximate Intervel Between
3	Physician		SHOOK, OF HOME MINORE. CALL	orally sprain Cardiso Ori	each inte.							4		Onset and Death
	/Medical		Immediate Cause (Finel disease or condition	5	na	lan	_ (	of make	is	/	Dott	-1	×	second
	Examiner		resulting in death)	a	Du	e to (or as a c	onsequence	of):	0	./				
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	ifficate be executed in physician and es the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Du	e to (or as a o	onsequence	of):						0
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68760,	ificate be execting physician endes the burial-tra	ope	resulting in death) Last		Du	e to (or as a c	onsequence	of):					i	
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o.	v requires that the death cer been signed by the attendin should be deteched for usa	Physician/M	Pert If. Other significant condition	ns contributing to d	death but r	not resulting in	the underly	Ing cause gi	ven in Part		23b. Did to	1		the cause of death?
7	that bed b	by Pi	Diahetes	Mell	de	7 /	top	out	ans	4	. ''''	98 212 NO	3   Proi	Daibly 4 Onknown
rds,	requires					1	00				24a. Was 8		24b. W	ere autopsy findings
000	shou	Completed									perfor	med?	COL	ailable prior to mpletion of cause death?
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VII	ician: The certificate rector, pag	O	25. Was case referred to medical						29 Place	of Dont	h (Check only or			2103 225110
	Physician: this certific ral director,	To Be	examiner? 1 ☐ Yes 2 DNo	Hospitel:	Inpatient	2 ER/Out	Instient 3	DOA Ott	hor:			enca 8 DOthe	r (Specif	v)
0	g Phys eral di	-	27. Menner of Death	28a. Date	of Injury	28b. T	ime of	28c. Inju Wo				ow injury occurre		
0	Attending or death. ector: After by the fune	atlo	1 ØNaturaf 5 ☐ Pendin 2 ☐ Accident investig		nth, Dey Y	ear) II	njury M		Yes 2	No				
DIVISION	er de	tific	3 Suicide 6 Could r	nod 200. Plac	e of Injury	- At home, far	rm, street, fa	ctory, offica			28f. Location (S City or Tow		or Or Rure	l Route Number,
5	rs aft al Di	Cer			,		1/2/2							
	To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical Certification:		g Physician: To the Examiner: On the t and mar		caminetion end								
	Withir To th	Me	29b. Signature and title of certifier					29c. Licens	se number		1	9d. Date signed	(Month,	Day, Year)
			Dean	· m	2/2	4-1	* MI	103	19-	19		10/0	9/	2000
			30. Name and address of puredry	who completed cau	e of deat	th (Item 23e) (	Type, Print)	, - 0	10	DAR	ROWN	57	1	
			GEORGE	MY	200	110	MI	)			ERTE	win	MI	3 2/620
	Sta	te	31. Dete filed (Month, Day, Year)		Registrar's	Signature	1	-				,		
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State of Maryland / Department of Health and Mental Hygiene 0 0 3262

			(	Certifica	te of	Death		Reg	. No.		L. O L., 1	
	1. Decedent's Nema (First, Middle, Li	ist)					2. Date Mor	of Death	Dey	Year	3. Tima of Death	
Physician /Medical	John Paniere									2000	0958	
Examiner	4a Facility Name (If not Institution, gi	ve street end number)				4b. City, To	wn, or Location o		4c. County			
	Kent & Queen Ann	e's Hospita	1			Chest	ertown		Kent			
Funeral Director		Sex 7. Aga	(In yrs. last birth	day) If Und Months	ar 1 Yaar Days	If Under Hours	Min. February	of Birth hth, Day Y	gar) 1907	9. Birthp Cour NoKom	elece (State or Foreigntry) is, Illinois	
dat	Usual Residence of Decedent  10a. Stete 10b. County		10c. City, Town	or Location						1	0d. Insida City Limits	
23a-1 potifies ecto	Maryland Queen	Anne's	Maryo	lel								
D 20	10e. Street and Number 1913 Peters Corne	er Road		10f. 2	ip Coda 216	49		10g. Citizen of What Country? USA				
ar, or itsms Examiner in by Funer	3X Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 22 No If Yes, Giva Year or Dates:				Hispenic Ori ean, Mexican Specify:	gin? (Specify Yea i, Puerto Rican, e	s or No- itc.)	Blee	ck, White, y: Whi	etc.	
lical lical sted	15. Decedent's E (Specify only highest gr		16e. [	Decedent's Us Giva kind of v	uel Occuj	pation during mos	t of working	16	b. Kind of B	Kind of Business/Industry		
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Be C		)				18. Mothe	er's Name (First,		-			
best o						Anna	Magnino	Prin	10			
The Party of the P	19a. Informant's Name/Relationship	(Type, Print)	19b.	Malling Addre	ss (Street		er or Rurel Route			, State, Zip	Code)	
27 18	Annabelle Taylor/	Daughter	191	3 Pete	rs C	orner	Road, M	arvde	1. MD	2164	.9	
y or othe	20a. Method of Disposition  **Disposition 3 [  4 Donation 5 Other (Special Content of the Conten	Removal from State	20b. Plece of I	Disposition (N , crematory of	eme of other ple	ice)	Date	20	c. Location	- City or To		
e attending physician and address as the burial-transit and side a		c. Mal	ue to (or as a co	que	lung	dizeas	e ex	acces		3 days 3 morth 2 weeks		
igned by the attendibe detached for use	Pert II. Other significant conditions	contributing to death buf	ntributing to death but not resulting In the underlying cause given in Part I.					23b. Did tobacco use contributa to the cause of de				
been s should should							24	a. Was an performe		av	ere autopsy findings vailable prior to impletion of cause death?	
certificate has rector, page 2 Be Comp								1 🗆 Yes	2 No	11	□Yes 280No	
or, p	25. Was case referred to medical					26 Place	of Death (Chec		700			
director.	examiner?	Hospital:	2 ER/Out	patient 3 🗆 I	Ot Ot	her-	ursing Homa 5		co 6 🗆 🗀 🖂	hor (Snaci	6.1	
	27. Manner of Death  1 Detatural 5 Pending	28a. Date of Injury (Month, Dey			28c. Inju		28d. De		injury occu		<i>y)</i>	
within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not lead to determined	De Diese of leive	y · At home, fari (Specify)				28f. Loc	cation (Stra or Town,	at end Num. State)	ber or Run	el Routa Number,	
within 24 hours after To the Funeral Director Completely filled in by Medical Certifi	29a. Certifier (Check only one) 1 Certifying Pl	nysician: To the best of miner: On the basis of e	xamination and	death occurre for investigation	d at the ti	ime, date en opinion, des	d plece, end due	to the cau e time, date	se(s) and m e end plece,	anner es s , end dua t	steted. o the cause(s)	
ithin of the omple	29b. Signeture end Utili of curlifles			2	9c. Licen	se number		290	1. Dete signe	ed (Month,	Dey, Year)	
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5	Name and address of person who	completed cause of dee	oth (Item 23e) (1	ype, Print)	0		1,00		11	010		
-12-30	Frederick Delboy	6602 Church	Hill B	Road, S	uite	200,	Chester	town	Mary1	and 2	1620	
State	31. Dete filed (Month Day Year) 6	2000 32. Regular	s Signature	B. ,	Spar	Ka						

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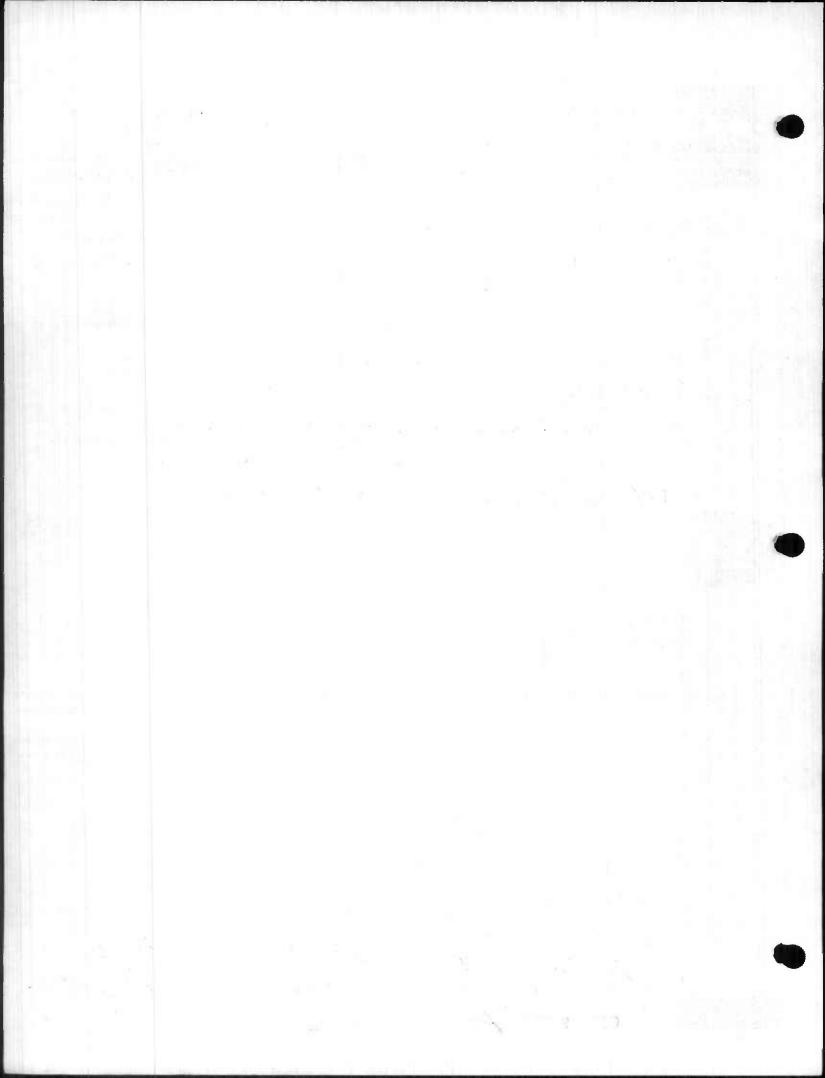
State of Maryland / Department of Health and Mental Hygiene

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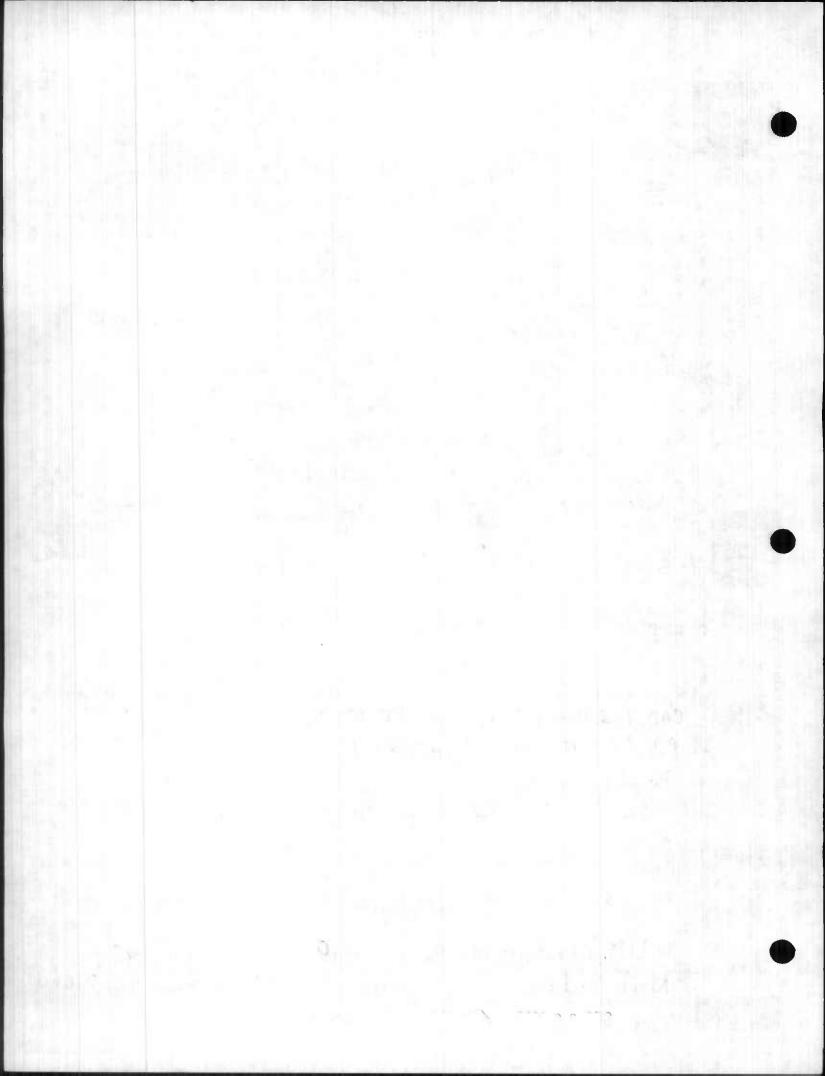
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Amended #1,	10/04/00, Tm, KentCastate of Maryland / Dep	artment of Health and Mertificate of Death	Mental Hygiene	00 32623							
	1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death							
Physician	Alice Mary Elizabeth Pickrell		Month Dey September 2	5, 2000 9:47 a.m.							
/Medical Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Lo		unty of Death							
CAUTITICI	142 Longfellow Drive	Chestert	own	Queen Anne's							
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,			9. Birthplace (State or Foreign							
Director	199-54-7096 1□ M 2NF 80 Yrs.	Months Days Flours Will.	8. Date of Birth (Month, Dey, Year) July 20, 1920	O Spring Brook, PA							
2 .	Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation *		10d. Inside City Limits							
athor at at				1 Yes No							
or 28s-fr	Maryland   Queen Anne's Cho	estertown 10f. Zip Code	10g Citizen	of What Country?							
mas 23	142 Longfellow Drive  11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	US. Decity Yes or No-	A. Raca - American Indian,							
Maryland 21215-0020 d 2 ahould be filed within 72 hours after death of 2 ahould be filed within 72 hours after death of 1 is marked other than "natural; or itsers 23a traumatic event, the Medical Examiner must traumatic event, the Medical Examiner must To Be Completed by Funeral	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No H Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☒ No Specify:		Black, White, etc. ecity: White							
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and sund	19a. Informant'a Name/Relationship (Type, Print) 19b. Mail	ing Address (Street end Number or Rur	ral Route Number, City or To	own, State, Zip Code)							
C 2 N 4		Longfellow Drive,	Chestertown,	MD 21620							
Ore Profits or oth	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State 20b. Place of Disposition cemetery, cre	osition (Name of matory or other place)	Date 20c. Locat	ion - City or Town, State							
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Ball permit Depart Import any in	21. Signature of Funeral Service Licensee 22. Name and Address of Facility  Ed. 11 and Address of Facility										
Physician /Medical Examiner	Immediate Cause (Final disease or complications as a Colon Cause)  Tellows, Reflection a Newham Funeral Home. P.A.  130 Speer Road, Chestertown, Maryland 21620  Approximate and Death Do not enter the mode of dying, such as cardiac or respiretory arrest, interval Between Onset and Death  Smorths  Approximate  Approxi										
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3760, Ite be executed systcian and he buriel-transit lical Examiner	Cause (Disease or injury that initiated events Due to (or as a consequence of):										
Division of Vital Records, P.O. Box 687 To the Heaptal or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate hes been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medic	resulting in death) Last										
P.O. I nat the delay the a setached f	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Pert I.	23b. Did tobacco us	e contribute to the cause of death?							
15, P. res that it signed by I be detac	CADZ WI 4/2000 HTN PVDZ D	VT/COPD/	1 Yes 2								
Division of Vital Records, or Attending Physicien: The law requires the after clearly. Director: After this certificate has been signed in by the funeral director, page 2 should be dertification: To Be Completed by	Mol / HxgIBI ced Hypothy	roid	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?							
The The Pege	Renal Insufficuer.		1 □ Yes 2401	No 1 ☐ Yes 2 ☐ No							
ita Ilen: ctor,	25. Wes case referred to medical examiner?	26. Place of Dee	th (Check only one)								
of Vital Re Physicien: The la r this certificate hes arel director, page 2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4 Nursing Ho	ome 5 Residenca 6	Other (Specify)							
D P P P P P P P P P P P P P P P P P P P	27. Manner of Death 1. Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at Work?	28d. Describe how injury o	occurred							
SiOn auth.	2 Accident investigation	M 1 Yes 2 No									
ivisite de la	3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, s building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Hospital o 4 hours afficureral DI ely filled in	29a. Certifier  (Check only 2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner as stated.										
the the hin 2 the f	one) and manner stated.	29c. License number	20d Date of	signed (Month, Day, Year)							
	29b. Signature and title of certifier  De Cook to All	D50996	9/3	25/00							
6		Brown St. Cl	hast or town	MD 21620							
State Registrar	SEP 2 6 2000 32. Registrar's Signature	9. Sports									

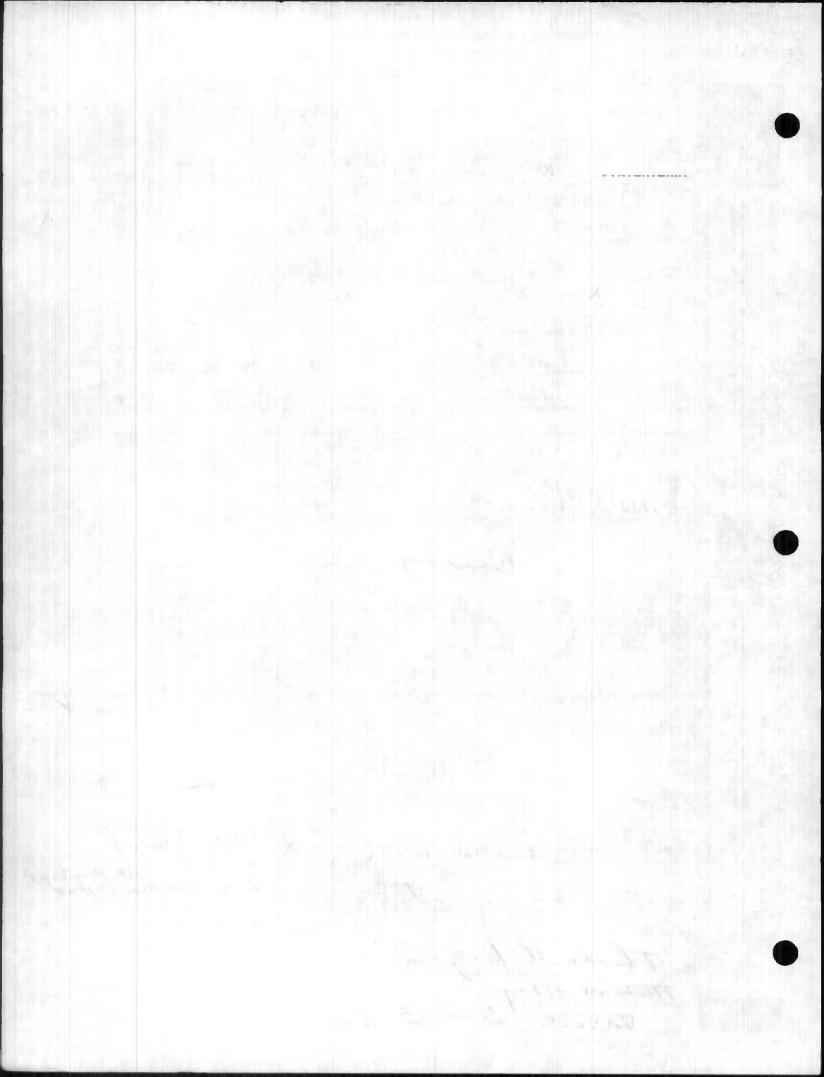
DHMH 16 Rev 6/95



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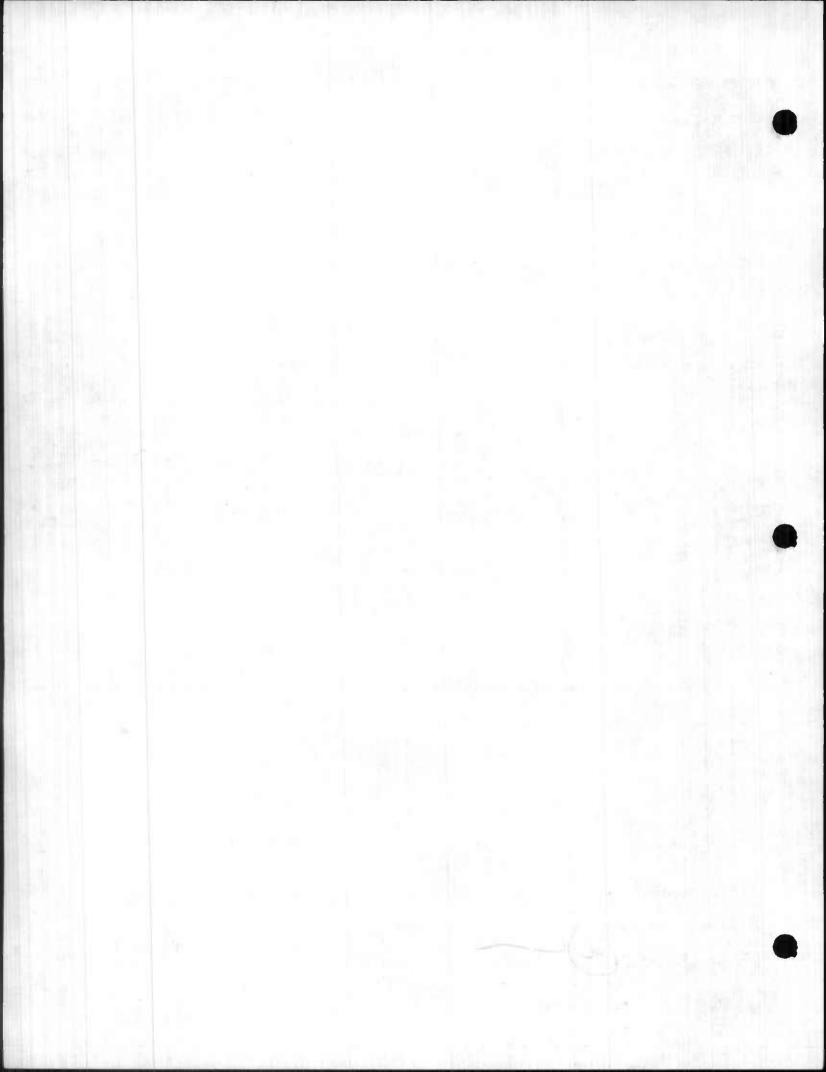
James William Phillips

Aı	mend Ite	m	#5,per FH 10/02	2/20	000 BG		(	ertificat	e of	Death		Reg. No.		0 - 0 - 7				
			1. Decedent's Nama (First, Midd							100	2. Data of De Month	eath Day	Year	3. Time of Death				
	Physicia /Medica		James			Weld	on		Phi	illips		ber 29,		8:08 P.M.				
	Examine		4a Facility Nama (If not institution	7.1						4b. City, Town, o	r Location of Deat	th 4c. County	of Death					
			Peninsula Rei	ona.	l Medica	l Cen	ter			Salish			omico	)				
	Funeral Director		5. Social Security Number 240 10 1623	6. S	ax M 2□F	. Aga (In yr:	s. last birthe Yr	Months					9. Birtho Cour Georg	placa (Stata or Foraign htry) gia				
	pue *		Usual Rasidence of Decedent 10a. State 10b. Count	v		10c. C	ity, Town o	r Location						Od. toside City Limits				
	dany!	0				4	nt	A						1 ☐ Yes 2 No				
	100 the	Director	MD Some	rse	C		Prin	cess A				10g. Citizen of	What Cour	ntry?				
	sth with the Maryler 23e or 28a-f show	5	12140 Drawbrid	ge	Road					853		US						
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21215-0020	72 hours after deeth with the Maryland "natural", or Rema 23s or 28s-f show sides Examples count by coursed at	by Funeral	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce		Armed Ford 1 A Yas 2 If Yes, Giva Yaar or Dat	as: WWI		1 Yas, spe	No.		arto Hican, etc.)	Specif		atc. nite				
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121		Completed	Elementary/Secondery (0-12)	1	College (1-4	4or 5+)		e DO NOT u ceiver	sa retire	during most of w	oarg	Groce	ry St	ore				
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	Examiner		diseasa or condition resulting in death)		a	Duato	(or as a cel	sequance of):					1					
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	icate be axecuted physician and s the burial-transit	Examiner	Sequentially list conditions,	-	b	Due to	(or es a co	nsequence of):										
o,	e axe		Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury															
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00	> 400											ormed?	CC	railable prior to empletion of ceuse deeth?				
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	To the To the Commerce	2	29b. Signature and title of certifi	er		v .		29		sa number		29d. Date signe						
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	1-UA											
State 31. Data filed (Month, Day, Year) 2000 32. Registrar's Signatura					irth St	Oakland,	MD 215	50				
Registrar		31. Data filed (Month, Day, Year)	32. Registrar's Sig	gnatura 4	diam.	2.4						



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | 32626 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEP 2 2000 Nettie Mabel Peck 4c. County of Death

4b. City. Town, or Location of Death

3. Time of Death

1:30 PM

Physician /Medical **Examiner** 

4e Facility Neme (If not institution, give street end number)

**Funeral** Director

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Physician /Medical Examiner

for use as the Mospital or Attanding Physician: 7
24 hours after death.
 Funeral Director: After this certifical director in by

completely

State

Registrar

SEP 2

To the Within 2

P.O. Box 68760

Records,

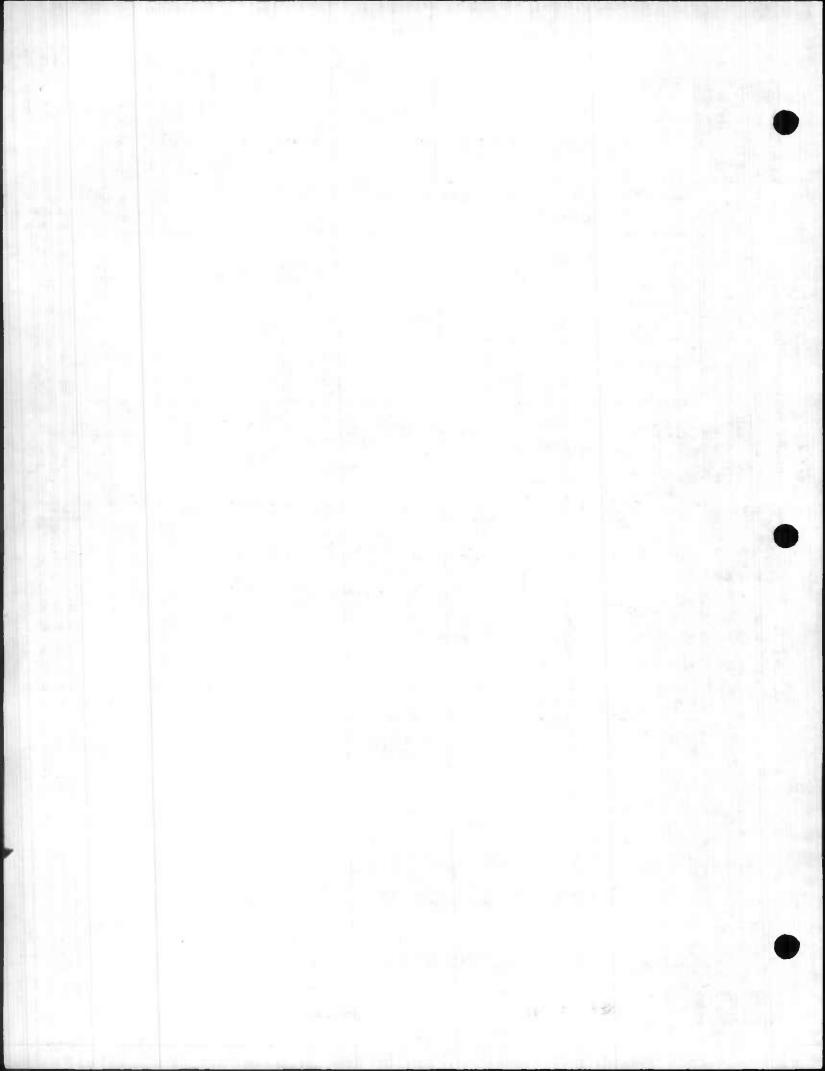
Division of Vital

Western Maryland Hospital Center Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Nov. 30,1911 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 1 ■ M 201 F YES 218-70-1292 Usuel Residence of Decedent Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1KIYes 2∏No Directo Mt. Lake Park Garrett 10f. Zip Code 10g. Citizen of What Country? 10a. Street and Number USA 21550 701 I Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Stetus 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specity: White 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 88 Missouri Belle Nine William Henry Speicher 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Barnard St., Frostburg, Md. 21532 Donald C. Peck/Son 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 9/25/00 Deer Park, Md. 4 ☐ Donetion 5 ☐ Other (Specify) Paradise Cemetery 21. Signeture of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death immediete Cause (Final diseese or condition resulting in deeth) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Pert I() Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Completed by 24b. Were autopsy findings available prior to 24a. Wes an eutopsy performed? completion of cause of death? 1 ☐ Yes 2 ☑ No 1 Yes 2 No 25. Was casa referred to medical examiner?

1 Yes 22 No Be 26. Place of Death (Check only one) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Many for of Deeth 28a. Dete of tnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 □ Accident 5 Pending 1 Tes 2 No investigation 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number 29d Pate signed (Month, Day, Year) 29b. Signeture and title of certifier 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 1500 Pennsylvania Avenue Rose Marie Chan, M.D. Hagerstown, MD 31. Date filed (Month, Dey, Year)

DHMH 16 Ray 6/95

32. Registrar's Signature



Piease Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #23 PART I, PER PHY G787 9-25-00 WR. Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey **Physician** August 17, 2000 6:00PM Jacqueline Rusch Pfaus /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** ROCKVILLE
# Under 1 Year | If Under 24 Hrs. | 8. Date of SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY 8. Date of Birth (Month, Day, Year) Sept. 21, 1926 Birthplace (State or Foreign Country) 7. Age (tn yrs. last birthday) **Funeral** Hours Months Days 1□M 20 F Yrs 388-22-8715 73 Wisconsin Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show iner must be notified at XXYes 2 □ No Director Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 234 10810 St. Paul Street 20895 United States Funeral Heme 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or its many injury or other traumatic event, the Medical Emerical page. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Public Schools Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 2 Milton H. Rusch Doris T. Mott 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurat Route Number, City or Town, Stete, Zip Code) 10810 St. Paul Street, Kensington, MD James G. Pfaus/Son 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) August 20 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 X Cremetion 3 ☐ Removal from State 2000 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Juneral Service Light 22. Name end Address of Fecility Robert A. Pumphrey Funeral Home/ 300 West Montgomery Avenue Rockville, Inc. M00803 20850-2805 Rockville, Maryland 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** RESPIRATORY FAILURE Immediate Cause (Final disease or condition resulting in deeth) /Medical Respiratory Failure with Possible Aspiration Examiner PNEUMONIA
Clostridium Difficle Colitis Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last and The law requires that the death certificate be execu-CLOSTRIBIUM DIFFICLE COLITIS P.O. Box 68760. Crest Syndrome Physician/Medical e da Due to (or es e consequence of) USB 88 CREST HYNDROME Po Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 signed t Records, þ 24b. Were autopsy findings available prior to completion of cause of death? director, page 2 should Be Completed 24a. Wes en autopsy performed? certificate has 1 ☐ Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1XXInpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No this funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Naturel 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Ruret Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) in by 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier completely ŝ 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 J. Blogaeli, MD August 18, 2000 D0054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli, 8609 2nd Avenue, Suite 404B, Silver Spring, MD

Registrar

State

31. Dete filed (Month, Day, Year)

AUG 2 1 2000

32. Registrar's Signeture

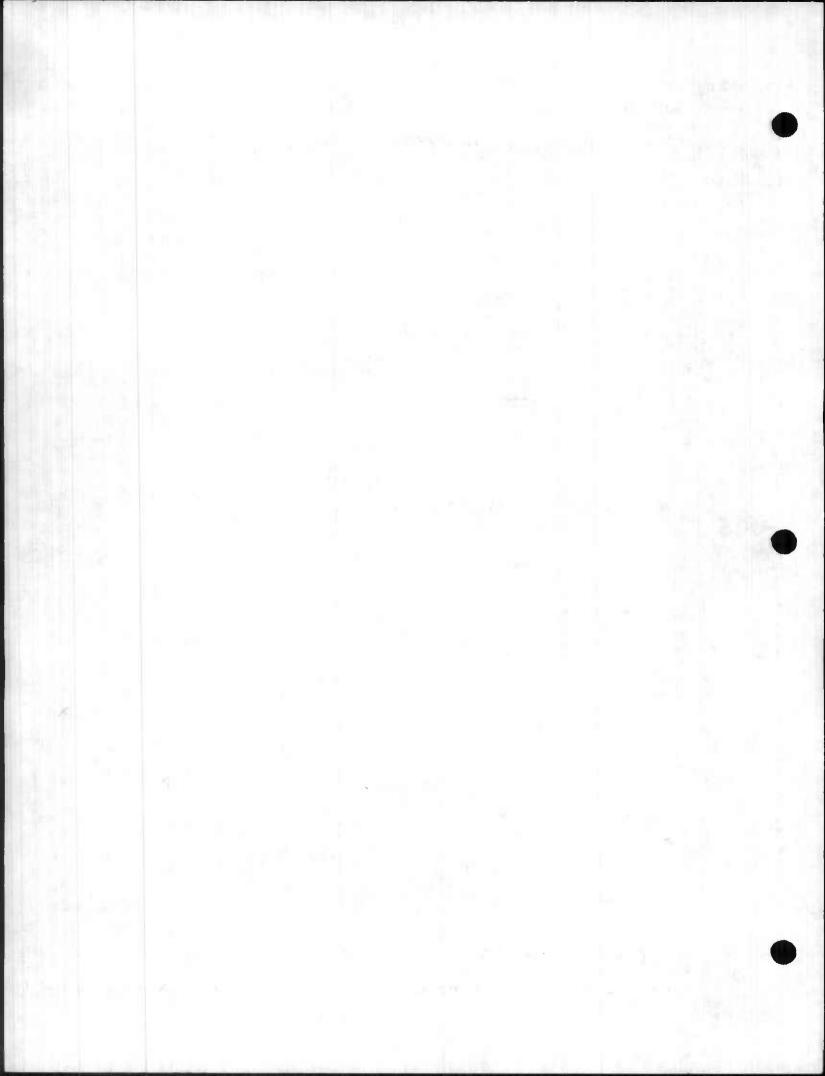
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State of Maryland / Department of Health and Mental Hygiene

		4. Donadoutto Namo (First Addd)	t eath		Cei	rtifica	te of	Death	2. Date of D	Reg. No.		3. Time of Dec	agth
Physici	an	1. Decedent's Name (First, Middle Q ) T U	Oll on	0			RF	Y	Month	Day	Year	15:10	
/Media	-	4a Facility Name (If not Institution	aive street end num	nber)			-	4b. City, Town, or I	OCTOR			12,10	
Examir	ıer	and the second s	PKINS		PITAL	15.1		BALTI	MORE	- 1			
Funeral Director		5. Sociel Security Number 225–36–3023		7. Age (In yrs. 70			r 1 Year	If Under 24 Hrs. Hours Min.		1930		olace (State or Fo otry) Lucky	'oreign
/land		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. inside City L	Limits
Men T	to	MD Har	ford		Aber	deer	1					1 ₩ Yes 2	□No
h the	rec	10e. Street and Number				10f. Z	p Code			10g. Citizen of V	Vhat Cou	ntry?	
death with the Menyland rms 23s or 28s-f show	alD	97 Smith Avenu	ie				2100	11	1200	U.S	.A.		
9 2 2	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marr 3 □ Widowed 4 □ Divorced	12. Was Dece Armed For ied 1  Yes If Yes, Giv Year or De	rces? <b>X</b> √XNo e		Was Deci If Yes, sp 1 Yes		dispenic Origin? (S an, Mexican, Puert Specify:	pecify Yes or N to Rican, etc.)	Specify	k, White,	can Indian, etc.	
	8	15. Decedent			16a. Deced	dent's Us	al Occu	pation	dia	16b. Kind of Bu			
215 Fin 7	Completed	(Specify only highes Elementery/Secondery (0-12)	College (1	-4or 5+)	life.	DO NOT	ork done ise retire	during most of world)	rking				
aryland 212: should be filed within and Mental Hygiena. merked other than	Con	11	0	,	Н	omema	ker			In ho			
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2000		19a. Informant's Name/Reletions						and Number or Ru					
E = 0 F		Reed Ray (Hush	band)	20h 1	9 / SI			nue, Aber	Date	20c. Location -	2100		
Baltimore, emit. Pages 1 a Appartment of Has mportant: If Itam iny injury or othe		1 ☐ Burial 2 ☐ Cremation		State	cemetery, crei	metory or	other ple						3
altim nit. Pa antmen ortant: Injury		4 Donation 5 Other (S)		Gr				an Cemet.	10/5/00	Aberde	en,	Maryland	1
Baltimo permit. Page Department of Important: If any injury or		21. Signature of Funeral Service	nellae	jude	L Al	arrir	ng-Ca	ess of Fecility argo Fune Maryland	21001	-3399			
		23a. Part1. Enter the disease, or shock, or heart feilure. List	complications that do	sed the dee ch line.	th. Do not ent	er the mo	de of dy	ng, such as cardia	c or respiratory	errest,		Approximete Interval Betwee Onset and Dea	en
Physician /Medical		Immediate Cause (Finel	1	5 YEAR									
Examiner		disease or condition resulting in death)  a. COROWARY ARTERY SISEASE											73
REAL PROPERTY.	Je.	Due to (or as a consequence of):											
58760, Hicate be associted physician and sthe burishtransit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b	Due to (	or as a consec	quence of	):	Sile :					
= 0 4	/Medical	that initiated events resulting in death) Last	d	Due to (d	or as a conseq	juence of							
death certification of for use as	Clar												1
P.O.	by Physician/M	Pert II. Other eignificant condition	ne contributing to de	ath but not res	sulting in the u	nderlying	cause g	ven in Part I.		I tobacco uae co ] Yee 2□ No			nknown
Records, P	Completed b								24a. Wa	s an autopsy formed?	8	Vere autopsy find veilable prior to ompletion of cause f death?	
Vital Re- licten: The lav certificate has inector, page 2	E								1	Yes 2 No	1	☐ Yes 2 No	0
ital	Bec	25. Wes case referred to medical						26. Place of De	ath (Check only	one)			
- 5 000	To	examiner? 1 Yes 2 No	Hospital:	npatient 2	ER/Outpatie	nt 3 C	OA O	her: 4 Nursing h	Home 5 Re	sidence 6 Oth	er (Spec	ity)	
On of ding Physith.  After this timeral di		27. Menner of Deeth  1. Neturel 5 Pendin 2 Accident investig		of Injury h, Dey Year)	28b. Time o Injury	f M	28c. Inju We 1 [	ry at ork? ] Yes 2 □ No	28d. Describe	how injury occur	red		
Division of Vital To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director; After this certificate completely filled in by the funeral director, pa	Certification:	3 Suicide 6 Could determ	nof be 28e. Placa	of Injury - Af h	ome, farm, str	reet, facto	ry, office		28f. Location City or T	(Street end Numb own, Stete)	per or Rui	rel Route Number	N,
Hospital     Aunoral     Funeral     Stephy filled	edical		g Physician: To the Examiner: On the ba and mann	isis of examine									
To the within 2 To the comple	Me	29b. Signeture and fittle of certifier 29d. Date signed											
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3		30. Name and address of person  DAVID ZARS					0 4	JOLFE A	ALTIM	RE. MA	RYLA	ND 313	187
Sta	ite	31. Date filed (Month, Dey, Year)	1	egistrer's Sign		3,50	1	- 0		, , , , , , ,			



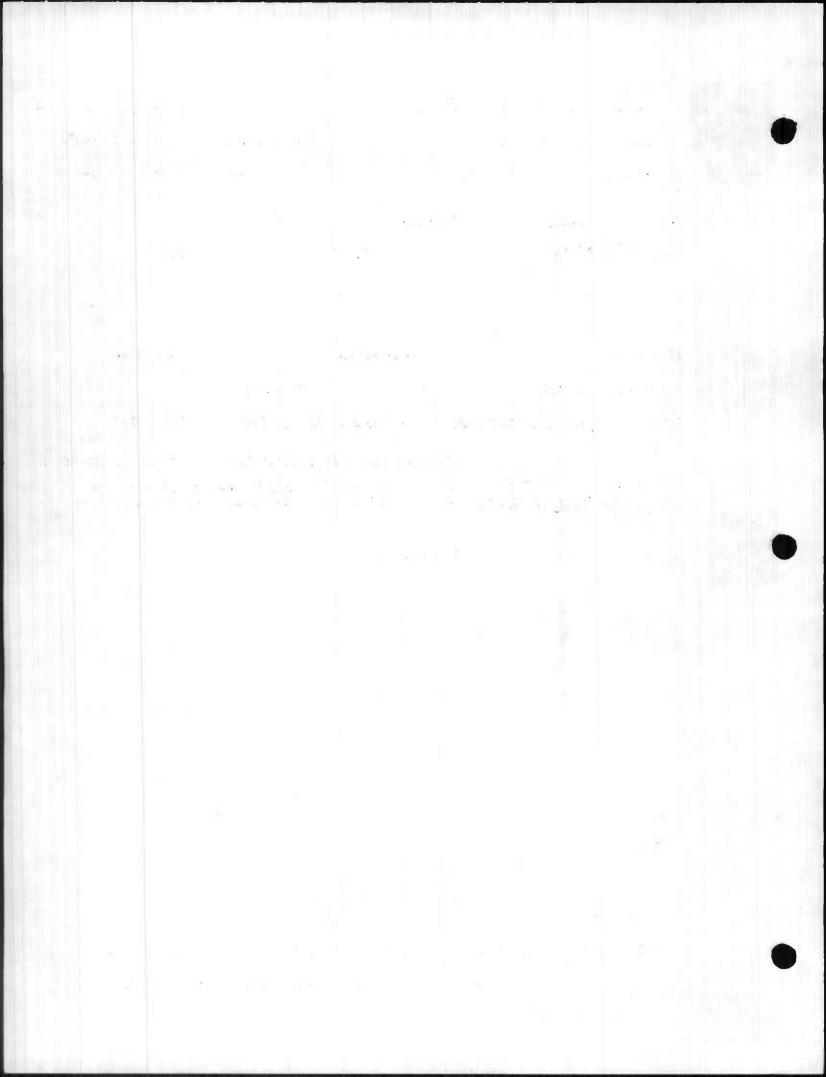
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Dey Month Year **Physician** ACI RYNES 23 NANCY 16=40 40 SUYPT 2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 204 FALLSTON HANFOND TERRACE 2504 If Under 24 Hrs. 8. Dete of Birth Hours Min. Scipt. 23, 1940 5. Social Security Number If Under 1 Year 9. Birthplace (Stete or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 X F Months Marilland 60 Yrs. 214-38-4332 Director Usual Residence of Decedent the Merylend 10c. City, Town or Location 10d Inside City Limits 10a State 10b County "naturel", or items 23a or 28a-f ahov edical Examiner must be notified at 1 ☐ Yes 2 X No MD. Directo Harford Fallston 10g. Citizen of What Country? 10e. Street end Number 10f, Zip Code with 2504 Roy Terrace 21047 U.S.A. Funeral Peges 1 and 2 should be filed within 72 hours efter deeth sent of Health and Mentel Hygiene.

Int: If item 27 is marked other than "naturel", or items 23 mir; if item of the unable event, in "sea" is a marked other than "naturel". 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 14. Race - American Indian, 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Betty Oppelt Frederick Baldauf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, Clty or Town, State, Zip Code) 2504 Roy Terrace. Thomas I. Rynes Sr. (Husband) Fallston. MD 21047 20b. Place of Disposition (Neme of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Stete Highview Memorial Gardens 9/26/00 4 ☐ Donation 5 ☐ Other (Specify) Fallston. Maryland 22. Name and Address of Fecility
Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licensee Wha 610 W. MacPhail Road, Bel Air, MD 21014 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final ASLVD disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner physician and the buriel-transit that the deeth certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as e consequence of): ettending ph for use es t 23b. Did tobacco use contributa to the causa of death? signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed is certificate has director, page 2 The 1 Yes 2 No 1 □ Ves 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funerai 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after deetl Director: 6 ☐ Could not be determined 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide In 24 hou.
The Funeral Direction 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier edical 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier DME OCME SUPT 23. 2000 9 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) SPABHU BELAIL NO BRAIN MD 21014 MO 728 31. Date filed (Month, Day, Year) SEP 2 6 2000 32. Registrar's Signature

**DHMH 16 Rev 6/95** 

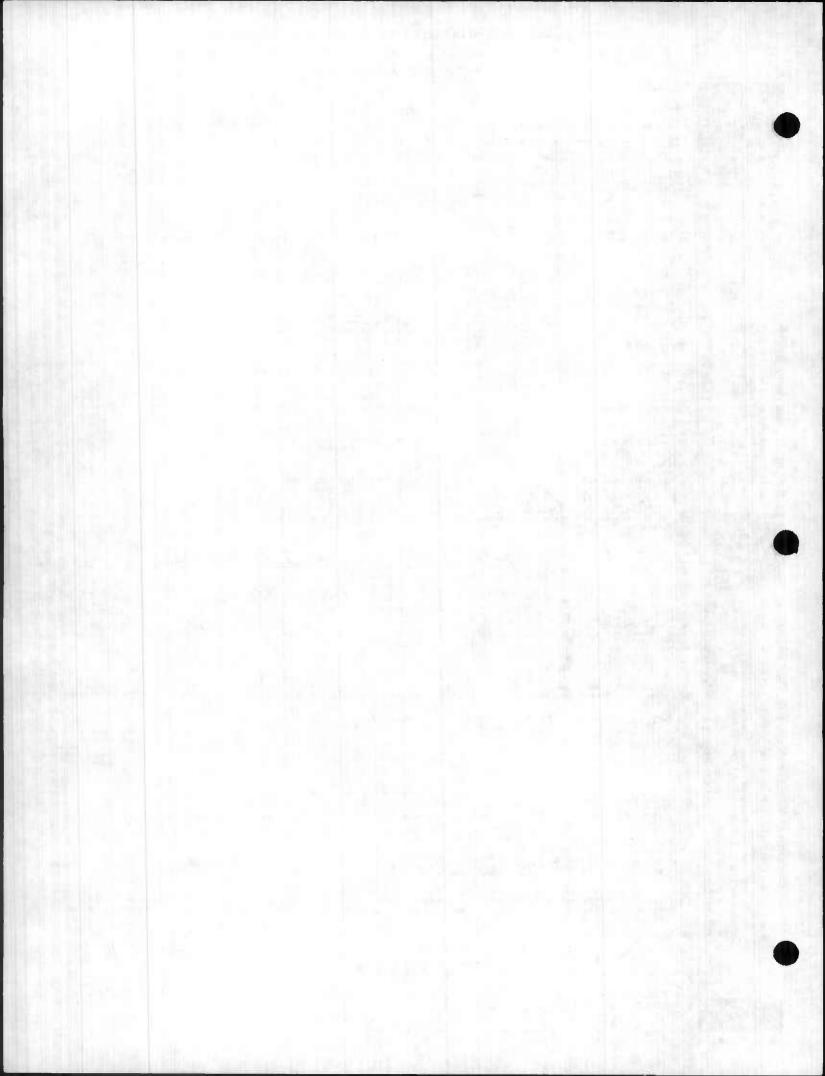
State Registrar



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

				State of Ma	aryland	/ Departme		Health and I Death		giene Reg. No.	00	32630
		1. Decedent's Nama	(First, Middle, La	st)					2. Date of Dea		Year	3. Tima of Death
	Physician /Medical	Clemens		August		Riley			October	Day 2	000	1:15 pm
	Examiner	4a Facility Name (# r	not institution, giv	e street end number)			-	4b. City, Town, or I	ocation of Death	4c. County	of Death	
		Crofton	Convale:	scent Cent	er			Crofton		Anne	Arund	le1
	Funeral	5. Social Security Nur		Sex 7. Ag	e (In yrs. lasi	Months	er 1 Year Days		8. Data of Birt (Month, Day	h y, Year)	9. Birthpl	aca (State or Foreign
	Director	495-24-19	38/	IAM 2UF	70	Yrs.			June 2	23, 193		10
	B *	Usual Residence of D	ecedent 10b. County		10c City T	own or Location					11	Od. Inside City Limits
	teryta de se		Charles		Wald							1 ☐ Yes 2 ☑ No
	with the Maryla s or 28a-f show be notified at Director	10e. Street and Numb					ip Coda			10g. Citizen of V	That Count	In/?
	1 6 8 D			J D1		101. 2		0.0				.,,,
	wa 23 mas 23	3465 A N	darigoi	12. Was Decedent	Ever in U.S.	13 Was Dag	206		necify Yes or No-	U.S.	A . a - Amarica	an Indian
_	har d	1 Never Married	1 2□ Married	Armed Forces?		If Yas, sp	ecity Cul	Hispanic Origin? (S ban, Mexican, Puert	o Rican, atc.)	Blac	k, White, a	
20	P. O.	3€ Widowed 4		1 9 garlos Give		1 ☐ Yes	2 XN0	Specify:		Specify	Whi	lte
21215-0020	2 PM 2		5. Decedent's Ed	ducation		6a. Decedent's Us	ual Occu	ipation		16b. Kind of Bu	siness/Ind	ustry
21	Med Med	(Specify Elamentary/Second	only highest gra	College (1-4or 5	5+)	life. DO NOT	usa ratire	e during most of wor ed)	King	T7 C	۸.	
2	In Dian	12		6		Lt. (	010	nel		0.5	5. A1	my
pu	Se file	17. Father's Name (Fi						18. Mothar's Nar				
yla	Mental of		D. Rile	У				Anna S	plisgar	dt Ril	.ey	
far	2 sh	19a. Informant's Nam						et end Number or Ru				
2,	and m 27	Shawn C.		Son				edge La		vie,Md.		
Ore	T to T	20a. Method of Dispo	sition Cramation 3	Removal from State	cem	e of Disposition (Ne etery, cremetory or	other pla		Date	20c. Location -	-	
E	Part Harry	4 Donetion 5	Othar (Specif	y)	Arli	ngton N	Vati	onal Ce	m. $10/1$	.7/00 A	rlir	ngton, VA
Sal	epar mpon ny in	21. Signature of Fune	aral Sarvice Licer	isee		AREHA	RATE	ECHOL'S	FUNERAI	HOME,	P.A.	
-	40264	Hari	1 6. 1.	lu )	MO094			567 La				
		23a. Part1. Enter the shock, or heert	disease, or com failure. List only	plications that ceusad one cause on each li	d the daath. I	Do not entar the mo	ode of dy	ring, such as cerdiad	or respiratory ar	rast,		Approximata tnterval Between
	Physician (Mandian)										1	Onset and Death
	/Medical Examiner	Immediate Cause (Fi disease or condition rasulting in daath)	nai	· Ath	Mos	clerati	C 7	leart I	SISAU	n		Years
	-	100000000000000000000000000000000000000		0	Due to (or as	a consequence of	f):					
	executed n and ial-transit		•	b. Pan				)15-Pa	»C		-	Jeans.
	be executician and burial-tran	Sequentially list cond if any, leading to imm ceuse. Enter Underly Cause (Disease or in	litions, nediate		Due to (or as	a consequence of	ı):					
760	siclan b buria	Cause (Disease or in that initiated avents		c	Due to for es	a consequence of	1.					
89	death certificate be execut e attending physician and ed for use as the burial-tran	resulting in death) La	st		Due 10 (01 es	a consequence of	,				1	
Вох	at the death certifica d by the attending phetached for use as the Physician/Med		E	d							i	
	deat e att	Part II. Other significa	ant conditions c	ontributing to death b	ut not resultir	g in the underlying	causa g	iven in Part I.	23b. Did 1	lobacco use cor	ntribute to	the cause of death?
P.0	by the stached	M. 0+	ible -	Decula	+10	4000	2		10	Yes 25 No	3 Prot	pably 4 Unknown
Ś	the see of	1.000	pr.	Decubi	100)	ou co						
ord	The law requires sate has been sign, page 2 should be									an autopsy med?	ava	are autopsy findings allable prior to
ec	law ras by 2 st										of	mplation of causa death?
=	The la								101	ras 2000	1 🗆	Yes 2 No
of Vital Record	Physician: The laver this certificate has rai director, page 2	25. Was casa raferred axaminer?	d to medicel	Hospital:			10		ath (Check only o	ne)		
of	H S D	1 ☐ Yes 2 ☑ No. 27. Manner of Death	0	1 Linpatie		/Outpatient 3 [	DOA		lome 5 Resid			1)
	ding Ph After th funeral	1 Natural	5 Pending	28a. Data of Inju (Month, De	y Year)	lb. Tima of Injury M	28c. tnje We	ork? ☐ Yes 2 ☐ No	200. Describe i	now Injury occur	80	
Sign	Attending or death.  ector: After by the fune tiffication	2 ☐ Accident 3 ☐ Suicide	investigation		un - At home	, farm, street, facto			28f. Location (5	Street and Numb	er or Rure	I Route Number.
Division	tal or Attending P rs after death. al Director: After t led in by the funer Certification:	4 Homicide	determined	building, et	c. (Specify)	, raini, siroot, raote	ny, omoc		City or Tov			
7	24 hours 24 hours Funeral letely filled	29a. Certifier 1	Certifying Ph	ysician: To the best	of my knowle	dga, daath occurre	d at the t	tima, date and place	, and due to tha	cause(s) and ma	inner as st	ated.
	To the Hospital or Attank within 24 hours after deall To the Funeral Director: completely filled in by the Medical Certifical			niner: On the basis of and manner sta	f examination							
	within 2 to the comple	29b. Signatura and tit	le of certifier	PAUL III		2	9c. Licer	nse number		29d. Date signe	d (Month,	Day, Year)
		K	7 Kessi	nanol	19	MD	D	20108	3	101	2/0	00
		30. Name and addres	s of person who	completed cause of d	leath (Item 23	(Type, Print)			1	- ,	BOU	viemo.
		MAKE	SH F	FRORA	, m	. D. 1	43	00 Ga	LANT +	OXLN	#2	99
		21 Date filed (Month	Day Vosel	22 Pagieté	her Signature							

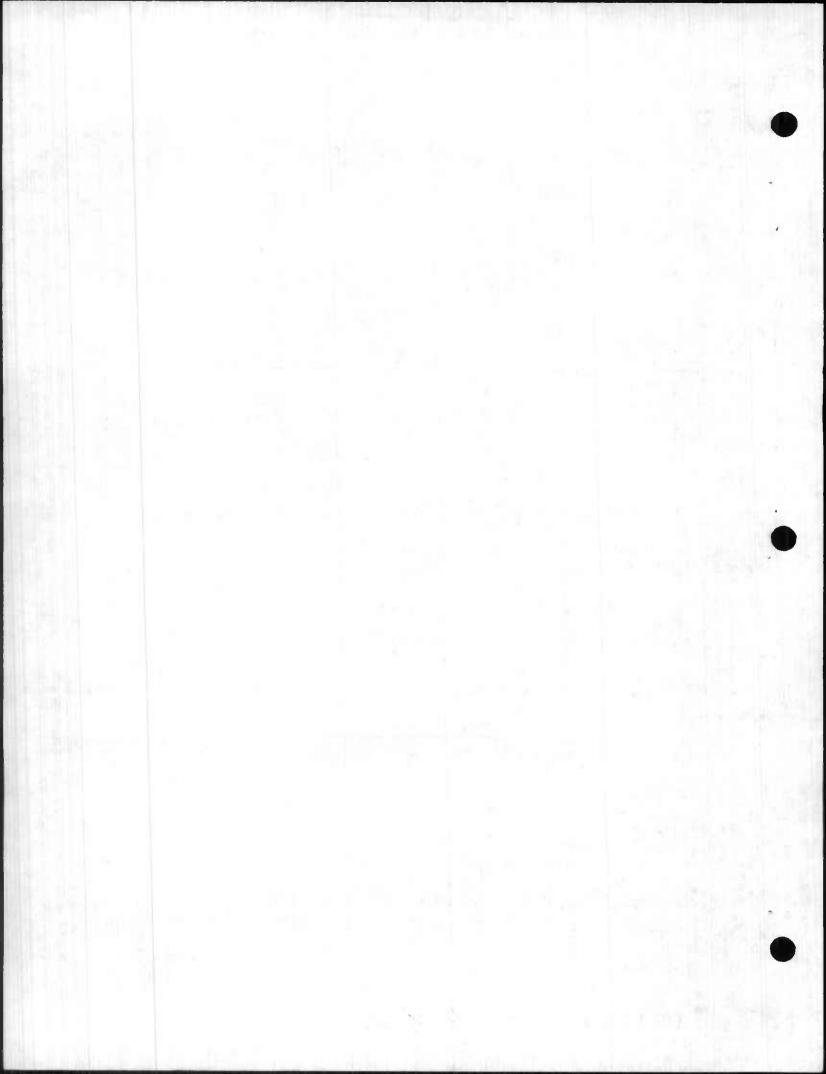
Registrar
DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

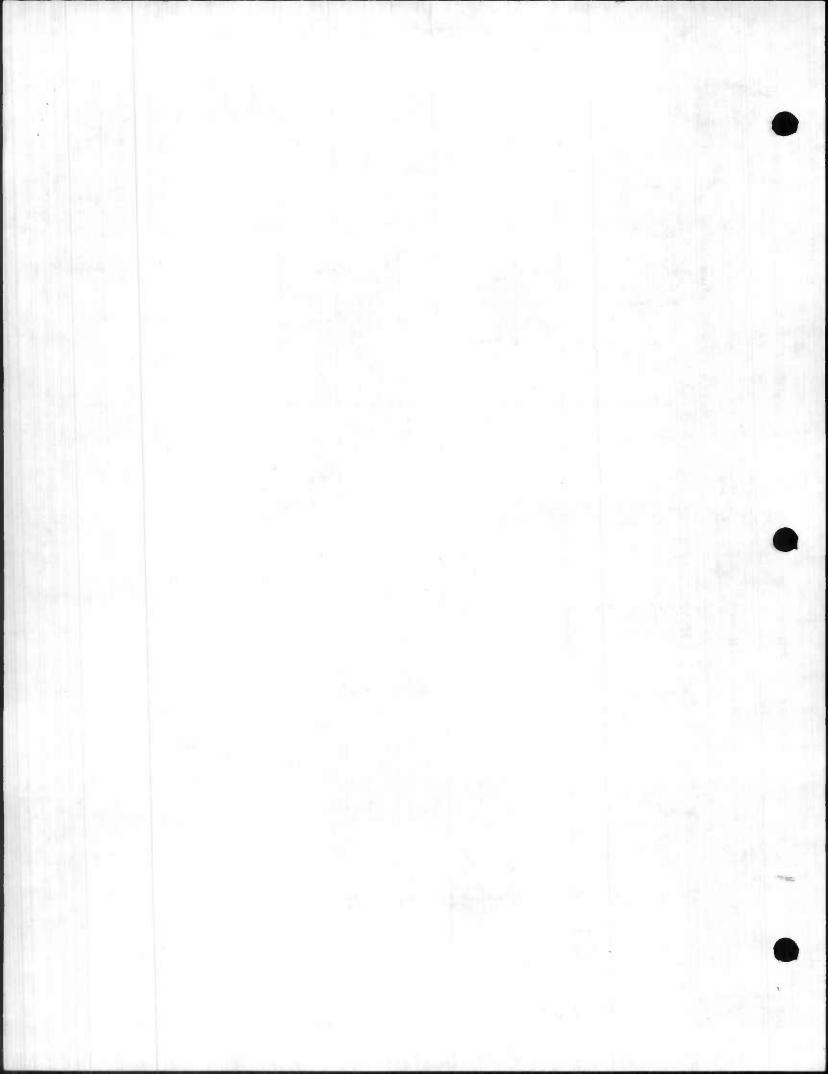
				Cei	rtificat	e of	Death			Reg. No.					
	1. Decedent's Neme (First, Middle	ecedent's Neme (First, Middle, Last)								eth Dev	Yeer	3. Time of Death			
Physician /Medical	ANN MARIE REZA	C							Month		5000	5:15 AM			
Examiner	4a Facility Name (If not institution	n, give street and n	umber)			-	b. City, To	wn, or Lo	ocation of Deeth	4c. Count	of Deeth				
	Saint Josep 5. Sociel Security Number	h Medic	7. Age (In yrs.		If Under	1 Yeer	T c	) W S C				imore			
Funeral Director	212-46-7664	1□M 2⊠F	55	Yrs.	Months	Deys	Hours	Min.	8. Dete of Bird 7 - 14 - 4	Yeer)	Mary	land			
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with the Maryland to c 28e1 show Libe notified at I Director		timore				imor	re Cou	unty				1 □ Yes XX No			
is 23 or 25s-f sho must be notified at eral Director	10e. Street and Number 119 West Elm Av	enue			10f. Zip	Code 212	206			10g. Citizen of USA	Whet Cour	ntry?			
her death r thems 23 siner must	11. Meritel Status	12. Wes De	cedent Ever in U	S. 13.	Wes Dece	dent of H	ispenic Ori	gin? (Sp	ecity Yes or No Rican, etc.)	- 14. Ra	ce - Americ				
hours after ural, or its at Examina d by Fu	1 Never Merried 2 Merr 3 Widowed 4 Divorced	If Yes C			1 ☐ Yes	V	Specify:	i, Puerto	rican, etc.)		ck, White, by: Whi				
ed within 72 ho ygene. er than *natura t, the Medical is Completed	15. Deceden (Specify only highe	t's Education of grade completed	)	16e. Deced	dent's Usu kind of wo	el Occup	ation during most	of work	vorking 16b. Kind of Busines			dustry			
m seem	Elementery/Secondary (0-12)		(1-4or 5+)	_	retar		,			Legal :	Induc	tny			
	12th grade 17. Father's Neme (First, Middle,	N/A	4	300	recar	у	18 Mothe	r's Nem	e /First Middle			CI y			
Mental H Mental H merked off wife ever	Ervin K. Rezac	Lasiy							s Neme (First, Middle, Meiden Surneme) esa E. Dunnigan						
ESEE	19e. Informent's Name/Reletions	hip (Type, Print)		19b. Mailir	ng Address	(Street	(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)					Code)			
and 2 selft a er trau	Theresa Ann Hol	obs		3035	Casc	ade	Dr. A	bing	don, Ma	ryland	land 21009				
and of He and of He A or oth	20a. Method of Disposition   20b. Plece of Disposition (Name of cemetery, crametory or other plece)   Date   20c. Location - City or cemetery, crametory or other plece)   New Cathedral Cemetery   10-10-00   Baltimore,														
emit. F opartm ny injur	21. Signature of Funeral Service														
0.02 6 0	Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236														
Physician	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.														
/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)	e. MET	METASTATIC BREAST CANCER												
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axecuted an and rial-transit Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events Due to (or es e consequence of):														
eath certificate be associted attending physician and for use as the bunal-transit clary/Medical Examir	Cause (Disease or Injury thet initieted events resulting in deeth) Lest	c	CDue to (or es e consequence of):												
death ce e attendi ed for us		d							1 00 014						
by the	Part II. Other significant condition	Other significant conditions contributing to death but not resulting in the underlying cause given in Pert										o the cause of death? bably 4 Unknow			
been sign should be				en eutopsy med?	ev cc	ere autopsy findings eileble prior to impletion of cause death?									
The law ata has be page 2 s									10	Yes 2 No	11	Yes 20 No			
Ficate No. Pe	OF Man case referred to medica						00 51	10				163 22710			
Physician: The rail director, pay rail director, pay rail director, pay To Be Co	25. Wes case referred to medica examiner?	Hospitel:				Oth	war.		th (Check only o						
F Sign	1 Yes 22 No 27. Menner of Death	114	Inpatient 2	ER/Outpatier 28b. Time of		JA	4 LINU	irsing Ho	ome 5 Resi	dence 6 LJOI how injury occu		(עו			
or death. ector: After by the funer iffication.	1 Neturel 5 Pendir investi	ng (Mo getion	onth, Dey Year)	Injury	м	28c. Injur Wor 1 🗆	k? Yes 2□	No	Zou. Describe	now injury occu	III OU				
24 5 E	3 Suicide 6 Could 4 Homicide determ	d not be mined  28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)  28f. Location (Street end Number or Ruccity or Town, State)								ber or Run	el Route Number,				
Hospi 14 hou Funer taly fill		(Check only 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)													
within 2 to the comple	29b. Signature end title of certifie				29	c. Licens	e number			29d. Date sign	ed (Manth,	Dey, Year)			
8484	29b. Signature end title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)  29d. Date signed (Month, Dey, Year)  29d. Date signed (Month, Dey, Year)														
	30. Neme end address of person	· ·	use of deeth (Iter		-	DRI	VE T	DWSI	DN. MA	RYLAND	212	04			
	31. Dete filed (Month, Day, Year)		Registrer's Sign												
State	00T 1 0 0000	6.	1	1											



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Mills.	Decedent's Neme (Fin)	at Middle Loo		iviai yiai		ificate of	Death		Reg. No.	00 32632	
Physician	233 200 200 200 100							Month	Dey	Year	
/Medical	Harvey	Ralph	RUGH						ber 22,		
Examiner	4a Facility Name (If not i						4b. City, Town, or l		4c. County	of Death	
	Garrett Cou					Whitedaya	Oakla			rett	
Funeral Director	5. Social Security Number	5 11	x	Age (In yrs.		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De	th ly, Year) 7, 1914	9. Birthplace (State or Foreign Country) Pennsylvania	
death with the Maryland me 23e or 28e4 show Linest be notified at	Usual Residence of Dece 10a. State 10b.	County		10c. Ci	ty, Town or Loca	ation				10d. Inside City Limits	
of or other	PA A	lleghe	ny		0al	kmont				1 X Yes 2 ☐ No	
1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	10e. Street and Number					10f. Zip Code			10g. Citizen of V	Vhat Country?	
National Park	223 Washing	ton Av	e.				15139		U	SA	
or he mines	11. Marital Status  1 Never Merried 2  3 Widowed 4 E		12. Wes Deced Armed Forc 1 Yes 2 If Yes, Give	es? ②No	C 100	es Decedent of Nes, specify Cub	dispanic Origin? (Si an, Mexican, Puerti Specify:	pecify Yes or No Rican, etc.)	14. Race Blee Specify	e - American Indien, k, White, etc.	
hour d b			Year or Det	9S: ////	1 40 5				White		
permit. Pages 1 and 2 should be filed within 72 hours begand not Health and Mansial Hyghers. Important; if them 27 is marked other than "returns", eny injury or other traumatic avent, the Health and pages.  To Be Completed by	(Specify on Elementary/Secondary 12th	Decedent's Edu ly highest grad (0-12)	de completed)  College (1-4	or 5+)	Steelwo		oation during most of world)	king	Sec. 14	siness/Industry  Production	
Be Coth	17. Father's Name (First,	Middle, Last)					18. Mother's Nan	ne (First, Middle	Meiden Sumem	e)	
Mente Mente dica		***		Rugh			Mary			emaley	
and	19a. Informant's Neme/R						and Number or Ru			Stete, Zip Code)	
and melth	Kathleen Pe		/Niece		2105 N		load, McHe	enry, MI			
OF THE	20a. Method of Disposition	20c. Location -	City or Town, State								
Peg int: If iry o	4 Donation 5 0				lvary C	emeterv		9/26/00	Pittsbu	rgh, PA	
Departi Departi Importu eny inje	21. Signature of Funeral	Service Licens	0/1/20		22. I	Name and Addre	uneral Ho	ome Ookland	MD 2	1550	
Physician	23a. Pert i. Enter the dis shock, or heart feilu	ease, or comp ire. List only o	lications thet cause on eed	sed the deel th line.	th. Do not enter	the mode of dyi	ng, such es cardiac	or respiretory e	rrest,	Approximata tntervel Between Onset end Death	
/Medical Examiner	Immediate Cause (Final disease or condition		Ac	cute M	yocardia	al Infar	ction			Immediate	
	resulting in death)		a		or as a conseque						
2 2			AS	SHD-Ch	ronic					Years	
cate be executed physician and the burlet-transit	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	ns, ate	С.	Due to (d	or as e conseque	ence of):					
	that initiated events resulting in death) Last	l									
d for d for	Part II. Other significant	conditions co	ntributing to deal	th but not res	ulting in the und	lorhring cause oi	ren in Pert t	23b. Did tobacco use contribute to the cause of			
ed by the detache			r Diseas		oneng in the title	enying cause gr	on air oil t.		Yes 20 No	3 Probably 4 Unknow	
aw requi		to other	- 5/11						en eutopsy emed?	24b. Were autopsy findings available prior to completion of cause of death?	
Page Com								10	Yes 2 No	1 ☐ Yes 2 ☐ No	
certificate rector, pag	25. Was case referred to	medical					26. Place of Dee	th (Check only	one)		
this certifical director,	examiner? 1 ☐ Yes 2 ☑ No		Hospitel: 1 🔯 Inc	atient 2	ER/Outpatient	3 DOA OH	nor		dence 6 □Oth	er (Specify)	
Attending Phy is death. Setor: After this by the funeral iffication: T	27. Manner of Death	Pending investigation	28a. Dete of (Month,		28b. Time of Injury	28c. Inju			how injury occur		
	3 Suicide 6 C	Could not be determined	28e. Plece of building	Injury - At h , etc. (Special	ome, farm, stree (y)	t, factory, office		28f. Location ( City or To	Street and Numb wn, Stete)	er or Rural Route Number,	
Hospi 4 hour Funer taly fill	29a. Certifier 1 💢 ( (Check only 2 🖺 la	Certifying Phy Jedical Exami	eician: To the be ner: On the basi end manne	s of examina	wledge, death o ition end/or inve	occurred et the ti stigation, in my o	me, date and place opinion, death occu	and due to the rred et the time,	cause(s) and me date end place,	nner es stated. and due to the ceuse(s)	
within 2 to the comple	29b. Signature and title of cartino.								29d. Date signed	d (Month, Day, Year)	
	D15333							33 9/22/00			
.0	30. Name and address of						100				
10	Dr. Thomas			311 N	. Fourth	St., 0	akland, N	Maryland	21550		
State Registrar	31. Date filed (Month, Da	P 2 5		istrar's Sign		Lon	0/1				

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 2. Deta of Deeth 1. Decedent's Neme (First, Middle, Last) Sally Janiak Rosemont 9 Sept 2000 7:40PM 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street end number) 4c. County of Death St Mary's St Mary's Nursing Center Leonardtown If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) 1□ M 2XF Vrs 304 12 9220 Nov 14 1912 Illinois Usuel Residence of Decedent 10e. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County Yes 2□ No St Mary's Leonardtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21585 Peabody Street 20650 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexican, Puarto Rican, atc.) 14. Reca - American Indian, Black, White, etc. 11. Maritel Status 1 ☐ Never Married 2 ☐ Married Specify: White 1 Yes 2 No Specify: 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Musician Music 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Antony Janiak Bessie Kazoved 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Henry Rosemont Jr. 20058 Havirland Ct., Lexington Park, Md 20653 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State Washington DC Sept 9 Geo. Washington Univ. 4 Donetion 5 Othar (Specify) 2000 22. Name end Address of Facility ral Service Mcensee Columbia Mortuary Services P.O. Box 58007 en 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart leiture. List only one cause on each line. Onsat and Daath 3 weeks Immediate Cause (Finel disaase or condition resulting in deeth) Failure of major organ systems Due to (or as e consequence of): 8 weeks Heart Failure Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Atherosclerotic hypertension vears Due to (or as a consequanca of): 23b. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en autopsy performed? 1 ☐ Yes 20 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) examiner? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of Injury 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

physicien end the buriel-transit the death certificate be executed Box 68760. ettending pl signed by the e The law requires that Division of Vital Records. should b hes i certificete he Physician: After this death ector: A

or Attending the Funeral Direction of filled in by

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mentel Hygiene.
Important: If Item 27 is marked other than "natural", or iten any injury or other treumetic event, the Medical Example page.

**Physician** 

/Medical

Examiner

Physician/Medical Examiner

Š

Completed

Be

To

Certification:

edicai

4 Homlcide

(Check only one)

29b. Signature and little of

Eugene

31. Date filed (Month, Dey, Year)

29a. Certifier

altimore, Maryland 21215-0020

Director

Funeral

py

Completed

Be

with the Meryland

death

To the Hosp within 24 hor To the Fune completely fi (2

State Registrar

DHMH 16 Rav 6/95

SEP 2 7 2000

Guazzo,

30. Name and address of person who completed cause of death (nem 23e) (Type, Print)

M.D.



Spark

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licansa number

DO-2159

Maryland Infirmary, Chaptico, MD 20621-0002

29d. Date signed (Month, Day, Year)

September 18, 2000



SEP 25 2000

ST. MARY'S CO.
HEALTH DEPARTMENT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 325, 27, 28a-f perMEOG 795 5/2/01 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Day Year **Physician** Month Linda Ann Petras Reiher September 8, 2000 6:45 p.m. /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Bayside Care Center St. Mary's Lexington Park If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 F Vrs Director 7, 1948 432-94-4032 California Usuai Residenca of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Directo St. Mary's Maryland Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21412 Great Mills Road 20653 U.S.A. Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 🔏 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 Married 1 Yes 2 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiana. Elementary/Secondary (0-12) College (1-4or 5+) Personnel Specialist Dept. of the Navy traumatic event, pemit. Pages 1 and 2 should be file Department of Haaith and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic events. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be (unknown) 2 Raymond Kelling Lee Ann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard A. Reiher / Husband 2572 Ocean Gateway, Trappe, Maryland 21673 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, cremetory or other place) 1 ☐ Burial 2 ■ Cremation 3 ☐ Removal from State Crematory Prinsfield-Echols 4 ☐ Donation 5 ☐ Other (Specify) 9-10-00 Charlotte Hall, Maryland 21. Signature Figural 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD In 20650 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medicai Immediate Cause (Final disease or condition rasulting in daath) Examiner Dua to (or Examiner artre Due to (or as a consequenca of): physician and s the burial-tran Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest certificate be axec Physician/Medical Due to (or as a consequenca of) attending for usa as ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes bengis be dat þ 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed been hes page 2 2 1 Yes 2 No 1 🗆 Yes cartificeta or Attending Physician: eftar daath. Director: Attar this carific director. 25. Was case referred to madical Be 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28c. Injury 4t 28b. Time of 28d. Describe how Injury occurred Certification: Date of Injury (Month, Day Year) 5 Panding investigation Injury Matural Subject fell backwards down a 1 Yes 2 No 2 X Accidant 11-27-89 Unknown AM flight of steps
281. Location (Street and Number or Rural Route Number,
City or Town, State) 3 ☐ Suicide 6 Could not be datarmined á

Records, P.O. Box 68760. Division of Vital

altimore, Maryland 21215-0020

Hospital 24 hours 24 hours e To the To the To the

State Registrar

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Medical

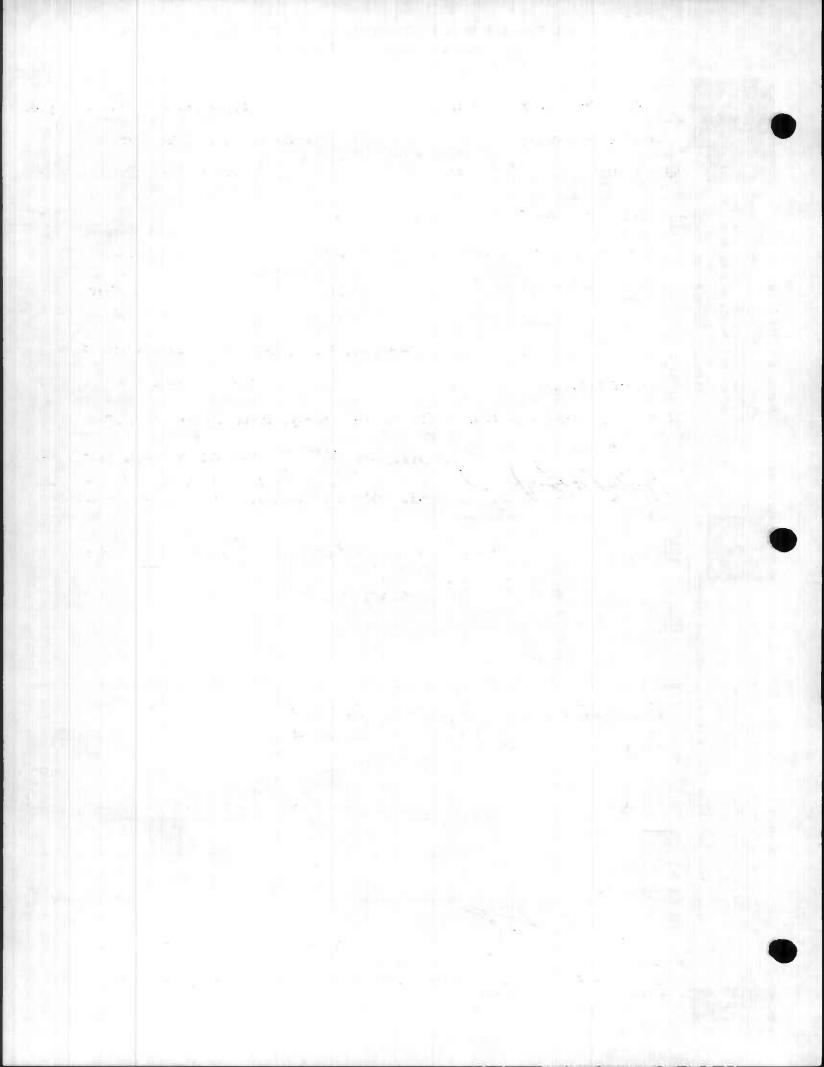
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4

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida Fajardo, Puerto Rico Apartment Complex Certifying Physician: To the base of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examine: On the base of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title defiliner 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and addrass of purely who Mth (Item 23a) (Type, Print) 23415 James C. Three Notch Road, California, Maryland 20619 Hoyd, M.D.,

31. Data filed (Month) strar's Signature

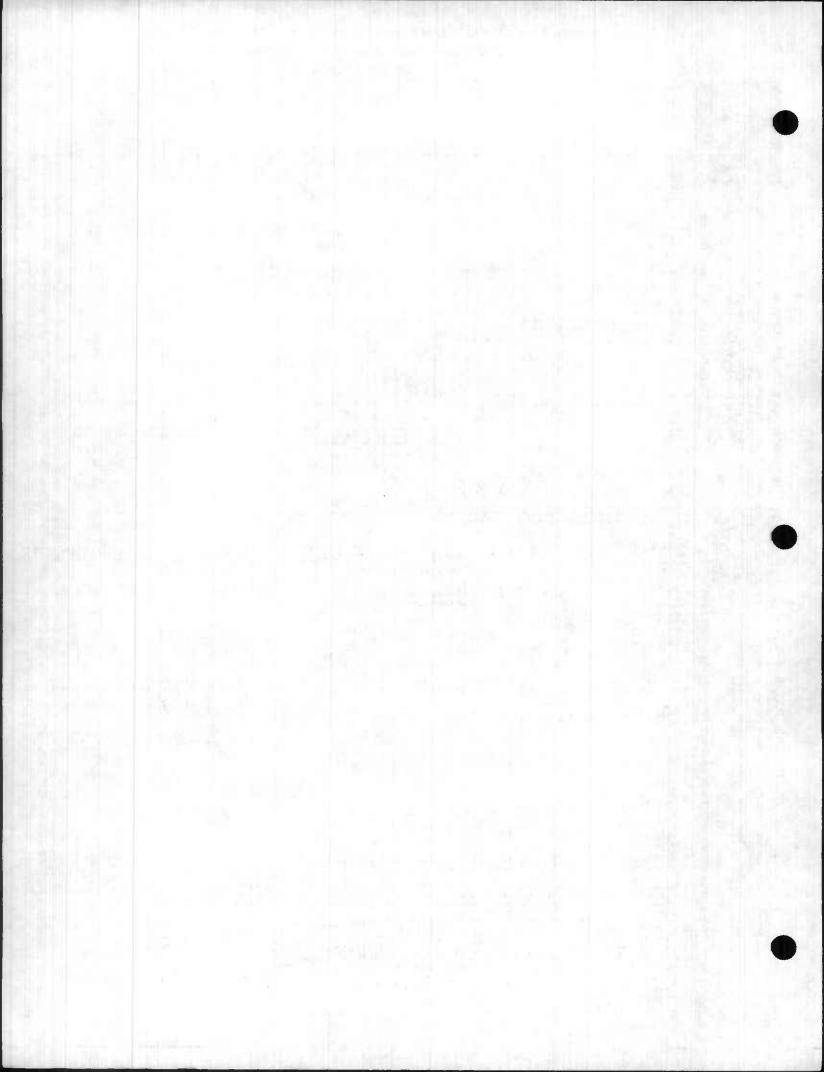


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State

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e of Maryland / Department of Health and Mer	ntal Hygiene	32635
Certificate of Death	Reg. No.	

				C	ertifica	ite of	Death			Reg. No.		
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Physicia	_	Beatrice Mar	ie Sav	lor					Month	ber 28 2	Year	7:10 PM
/Medic		4e Facility Name (If not institution, give		101			4b. City, Tov		ation of Deat			7 7 2 3 7 1 1
Examine	er	10955 Green Vall	CHARLES AND				Union	Bri	daa	Fred	oricl	
Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthd		ler 1 Yeer		24 Hrs.	8 Date of Bir	rth		place (State or Foreign
Funeral Director		212-38-7708	□M 2MF	91 Yrs	Month	s Deys	Hours	Min.	(Month, De	3, 1909	Cour	shington DC
Birector		Usuat Residence of Decedent		71					riai cii	3, 1,00	wat	mingeon be
a ga		10a. State 10b. County		10c. City, Town or	Location			100			1	Od. Inside City Limits
Many Many Many Many Many Many Many Many	tor	MD Frederi	ck	Union B	ridge							1 ☐ Yes 2 🛣 No
128 To	Director	10e. Street and Number	CR	OHIOH D		Zip Code				10g. Citizen of W	/hat Cour	ntry?
The or the	O le	10955 Green Valle	v Rd			21791				U.S.A.		
er Geath with the Maryla therm 23a or 28e-f shor her must be notified at	era	11. Marital Status	12. Was Decedent Ev	ver in U.S. 1				gin? (Spe	cify Yes or No Rican, etc.)		- Americ	en Indian,
	Funer	1 □ Never Married 2 Merried	Armed Forces? 1 ☐ Yes 2 ☑ No					, Puerto F	Rican, etc.)	Biec	k, White,	etc.
21215-0020 d within 72 hours all glens. r than "natural", or the Medical Exam	þ	3 ☐ Widowed 4 ☐ Divorced	tf Yes, Give Yeer or Dates:		1 🗆 Yes	2 No	Specify:			Specify	Whi	te
Pho Pho	B	15. Decedent's Ed	lucation	16a. De	cedent'a Us	suel Occup	pation			16b. Kind of Bu	siness/Inc	dustry
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the sense	E	Elementary/Secondary (0-12)	College (1-4or 5+)		cher					public	sch	001
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and by and	To Be	Clarence Diehl	Lena							P		
The state of the s	F	19a. informant's Name/Relationship (	Type, Print)	19b. M	eilina Addre			per, City or Town,	State, Zic	Code)		
Maryland d 2 should be the th and Mental Hy T is marked othe traumatic avent		S. Herman Saylor										
		20a. Method of Disposition	- nusbanu	20b. Place of Di	10955 Green Valley Rd., Union Bridg  Ob. Place of Disposition (Name of cemetery, cremetory or other place)  Oct. 2  20c. Location							
00 00 00 00		1 Burial 2 □ Cremation 3 □								TT t D		MD
altimore mit Pages 1 partment of Hi portant: If Hen r Injury or oth		4 Donetion 5 Other (Specific		Johnsvi					2000	Union B	ridge	e, MD
Ba Ban		21. Signature of Funeral Service Licer	10x/2	00-1	22. Name	and Addre	ess of Facility	Ha	rtzler	Funeral	al Home	
- 40260		amarine	V. Harry		6 E.	Broad	lway,	Unio	n Brid	ge, MD		
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/Medical	50	Immediate Cause (Final disease or condition	. Kacur	cont 7	thro	mh.	otic	5	nako		i	Oct. 97
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9 4	ne		Hyper	tension								415
and but	Examin	Sequentially list conditions,	a. Recurrent thrombotic strakes  Due to (or as a consequence of):  b. Hypertersion  Due to (or es e consequence of):									1.
58760, cate be exect physician and the bunal-in	Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or es e consequence of):  Due to (or as a consequence of):										
68760, ifficate be ex g physician as the buria	los	thet initieted events resulting in death) Last	C. Di	ue to (or as a con	sequence o	f):						
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G 8 8 00 00 00 00 00 00 00 00 00 00 00 00	Physician	Part ti. Other significant conditions of	ontributing to death but	not resulting in th	e underlying	ceuse gi	ven in Part I.		23b. Did	tobacco use cor	ntribute t	o the cause of death?
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Alber Fune	lon	1 Natural 5 ☐ Pending	28a. Dete of injury (Month, Day	Year) Inju		28c. Inju Wo	ork? ]Yes 2 □ I			,,		
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Division or Attending after death. Director: After	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	, 311001, 1401	ory, omco				wn, Stete)		
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	-	/ av	cofe h	W		LDO	00090	96		11-51	00	
		30. Name and address of person who	completed ceuse of dea	ath (Item 23a) (Ty	Print)	) (	-	TK	-11	MIn		
		J. W. LARICAT	TE IM)	104N1	1 Jan	A, U	noton	W	Kidge	- LIAT	W)	
	te	31. Date filed (Month, Dey, Year)	32. Registrer	's Signature	4	1-	11					



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State of Maryland / Department of Health and Mental Hygiene 00 32636

	10000115			Ce	rtificate of	Death		Reg. No.								
П	». 24	1. Decedent's Name (First, Middle, Las	(1)				2. Date of Do	Day	Year	3. Time of Deat	th					
	Physician /Medical	Anna L. Savag	e				Septem	ber 26,	2000	2:40 AM	1					
	Examiner	4a Facility Name (If not institution, give	street end number)			4b. City, Town	n, or Location of Deat	th 4c. County	of Death							
		Genesis Eldercar	e - Loch Ra	ven		Balti	more	Bal	timo	re						
-	Funeral	5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year			rth Vand	9. Birthp	place (State or For	reign					
	Director	214-22-8845	□M 20(F 96	Yrs.	Months Days	Hours	Min. (Month, D	1,1903	Man	yland						
١.,	B.1100101	Usual Residence of Decedent					7 000	1,1700	11100 0	georra						
	a ga	10a. State 10b. County	10	c. City, Town or Lo	ocation				1	Od. Inside City Lin	nits					
	Mary Mary Mary Mary Mary	Maryland Baltimo	no	Ponn	y Hall				1 □ Yes 2 ☑ N		No					
	or 25a-f a be notified	10e. Street and Number		, 000	10f. Zip Code			10g. Citizen of								
	D 80 P	18 Gunview Farm	0+			1128			S.A.							
	oath with the Maryle mast be notified at erali Director															
	har death w r heme 23a siner must b Funeral [	11. Marital Status	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 🕱 No	r in U,S. 13.	Was Decedent of If Yes, specify Cut	Hispanic Origin ben, Mexican, F	n? (Specify Yes or Neuron Rican, etc.)	D- 14. Had Bla	ca - Americ ck, White,							
20	5 ×2 W	1 Never Married 2 Married	If Yes, Give		1□ Yes 2X No	Specify:		Specit	v: WI	rite						
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and 21215-0020	od within 72 ho rigiene. er then "nehun t, the Medical. Completed	12th Grade		H	omemaker				n Hon	ne						
Pu	Be Be	17. Father's Name (First, Middle, Last)				1	s Name (First, Middle	, Maiden Sumer	ne)							
/la	To I	John Wernsdorf	er			Kate	Baker									
ar)	of bridge	19a. Informant's Name/Relationship (7					or Rural Route Numi			Code)						
2	27 T T T T T T T T T T T T T T T T T T T	John Birkmaier (G	rand-son)	18	Gunview 1	Farm Ct	., Perry	Hall, MD	211	128						
re,	He de	20a. Method of Disposition	2	Ob. Place of Dispo	osition (Name of metory or other pla	2001	Date	20c. Location	- City or To	own, State						
mor	age age	1 Burial 2 Cremation 3 4 Donation 5 X Other (Specify					0/20/00	Daltim	0 10 0	Maruland	,					
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Bal	may be and a second	21. Signature of Furieral Service Licent	500	- '	Schimune	k Fune	ral Home,	Inc.								
	20240	1100	11		9705 Bel	., BAltimo	re, MD	6								
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.  Approximate Intervel Between Onset and Death														
	Physician				Onset end Death											
	/Medical	Immediate Cause (Final disease or condition	20	0219	,				1098							
	Examiner	disease or condition esulting in death)  a														
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ó	exe an er rial-t	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.														
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>	P 40 75	examiner?	Hospitel: 1 Inpatient	2 ☐ ER/Outpatie	nt 3 DOA O	Alexan and	sing Home 5 Res		ner (Speci	(v)						
of	or this	27. Menner of Death	28e. Dete of Injury (Month, Dey Ye	28b. Time o			T	how injury occu								
0	ding the stun	1 Natural 5 Pending 2 Accident investigation		ear) Injury		onk? ∃Yes 2 □ No	0									
IS	after death. Director: After I in by the funer ertification	3 ☐ Suicide 6 ☐ Could not be	286. Place of injury	At home, ferm, st	treet, factory, office	9			ber or Run	el Route Number,						
Division	is after death. If Director: After the funers of in by the funers Certification:	4 Homicide	building, etc. (5	Specity)			City or To	own, Stete)								
	portal filler	29a, Certifier 12 Certifying Phy	ysician: To the best of m	v knowledne deel	th occurred at the	time date and	place, and due to the	n boe (s) and m	126 19008	teted						
	Ne Hosp in 24 hou ne Fune pletely fil edical	(Check only 2   Medical Exam	iner: On the basis of exa	mination and/or in	vestigation, in my	opinion, death	occurred at the time	, date end piece,	and due t	o the cause(s)						
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by Medical Certif	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) and manner stated.  29b. Signatuse and title of certifier 29c. License number 1 , 29d. Dete signed (Month, Dey, Mean)														
	F 3 F 8	200. Signature and title of certifier	speed	License number 29d. Dete signed (Month, Dey, Near)					0							
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	7	30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print) 5 18	reesh	TRIPE	IRAW	定ル/							
		5601 Loch Kou	sen bloc	de Bou	llineo	le r	Md - 2	1239								
	State	31. Date filed (Month, Dey, Year)	32. Registrer's	Signature	Ina	1/2/		,								

31. Dete filed (Month, Dey, Year) State SEP 2 6 2000 Registrar

29b. Signeture end title of certifier

W.A. Riles

GBMC 32. Registrer's Signeture

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

6701

29c. License number

3. Time of Death

1:50 PM

10d. Inside City Limits 1 Yes 2 No

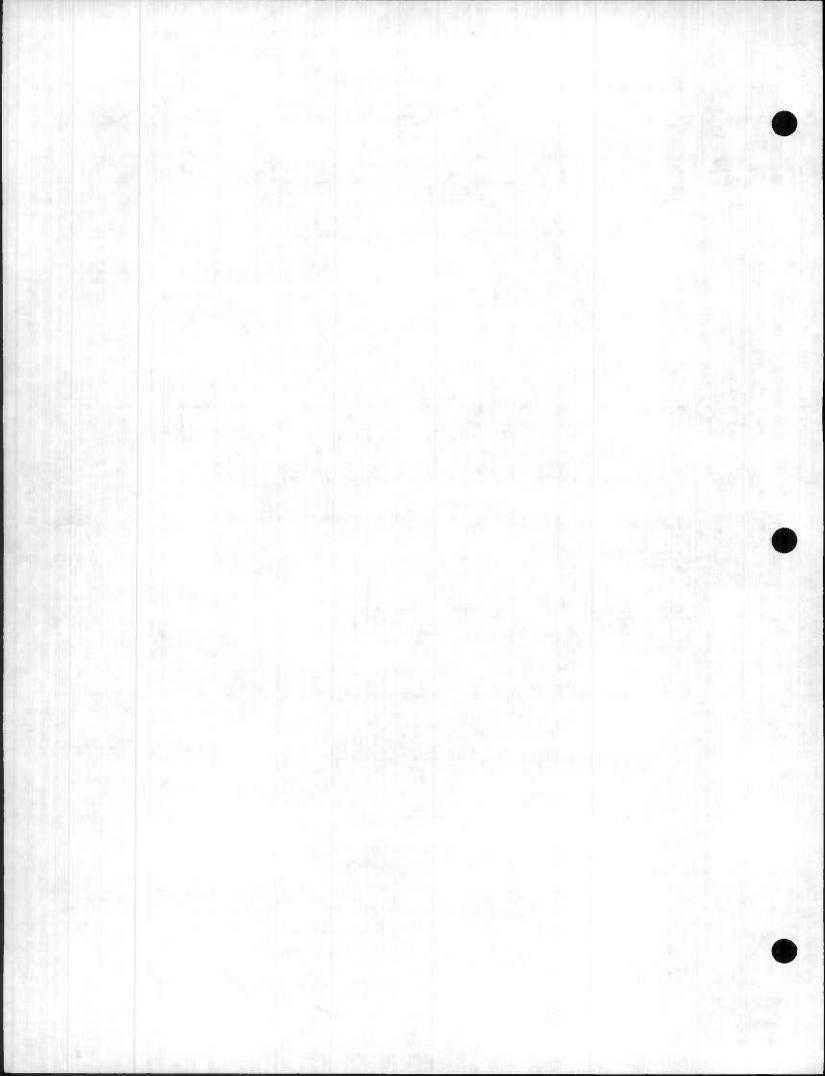
Approximete Intervel Between Onset end Deeth

1 Yes 2 No

2 months

Charles St -Balto, Md

29d. Date signed (Month, Dey, Year)



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32638 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth September 1 Year 050 A 2000 LINDA S. SMITH 22 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Harford Hospital 7. Age (In yrs. last birthday) Fallston General Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) Months Days 10 M SELF 213-52-6893 52 N. Carolina 2/7/1948 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits PA York Fawn Grove 1 Yes X No 10e. Street and Number 10f. Zip Code 10n, Citizen of What Country? 17321 Box 180, Garvine Mill Rd. USA Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 Married 1 Yes ZNNo If Yes, Give Year or Detes: 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Education Custodian 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Frank Hodae Hazel Moxley 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis D. Smith- husband Box 180, Garvine Mill Rd., Fawn Grove, PA 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 € Rurial 2 Cremetion 3 Removal from State Bel Air Mem.Gdns 9/26/00 Bel Air, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensed 22. Name and Address of Fecility Harkins F.H.Inc., 600 Main St., Delta, PA 23 Bert 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, hock or heart failure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in deeth) ANAL CARCINOMA Due to (or as e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Due to (or es a consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 PNo 3 Probably 4 Unknown FAILURE 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manney of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 Homicide

sician and burial-transit 188 ata has been signed by paga 2 ahouid be detac certificata director, this After this funaral of To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral

Physician/Medical þ Completed 8 10 Certification:

**Physician** 

/Medical

Examiner

Director

Funeral

à

Completed

80

**Funeral** 

Director

Health and Mental Hyglane. Itam 27 Is marked other than "natural", or Nema 23s or 28s-f show other traumstic avent, the Medical Examinar must be notified as

filed within

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is merked oths any Injury or other traumeter

**Physician** 

Examiner

/Medical

altimore, Maryland 21215-0020

the Maryland

Division of Vital

State Registrar

Medical

2000

30. Name engleddress of person who completed cause of death (Item 23a) (Type, Print)

DWARDS MD. 2112 BELATIR RD FALLSTON MD 32. Reģistrar's Signeture

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

**DHMH 16 Rev 6/95** 

29a. Certifier

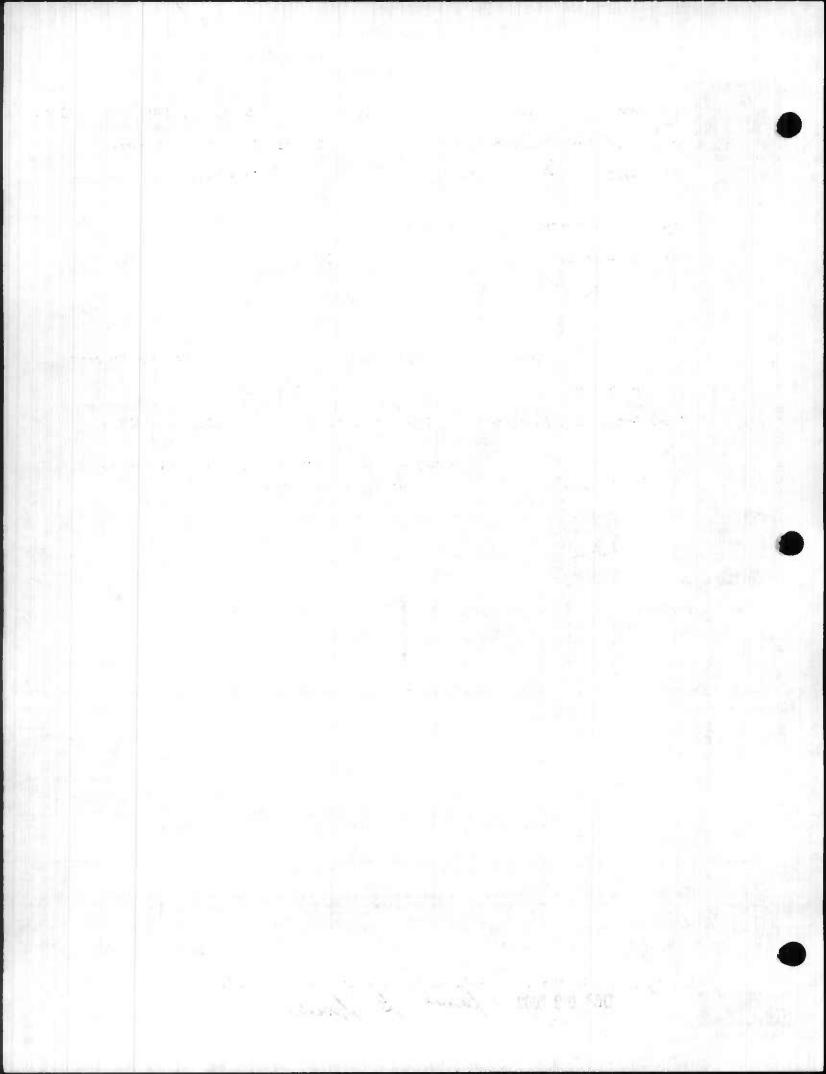
(Check only 29b Signature

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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Clarence Edward Spires Sept. 29, 2000 2:  Alice Byrd Tawes Nursing Home Crisfield Somerset  Crisfield  Somerset  Crisfield  Somerset  To Age (a large of Birth)  Addition and the Byrden of Death Accounty of Death Accoun	ion	Decedent's Name (First, Middle, Last)							2. Dete of D	eeth Dev	Year 3.	Time of Death		
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Secure the properties of the	0	Charl	es Spire	es					Addie	Elliot	t			
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Asbury U.M. Cemetery   10/01/00 Crisfield, MD		Vicki	Spires D	Dize/	Daught	er	3487	State S	treet, Ci	risfield	, Md. 21	1817		
Asbury U.M. Cemetery 10/01/00 Crisfield, MD  22. Name and Address of Fecility Himman Funeral Home 11673 Somerset Avenue, Princess Anne, MD.  Asports Himman Funeral Home 11673 Somerset Avenue, Princess Anne, MD.  Asports Himman Funeral Home 11673 Somerset Avenue, Princess Anne, MD.  Asports Asp							Plece of Dispo	sition (Neme of	ece)	Date	20c. Location -	City or Town,	Stete	
22. Name end Address of Facility Hinman Funeral Home  11673 Somerset Avenue, Princess Anne, MD. 238 Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, interventions of the disease or conditions.  Immediate Couse (Finel disease or conditions)  Sequentially list conditions.  Sequentially list conditions.  Sequentially list conditions.  Due to (or es a consequence of):  23b. Did tobacco use contribute to the caused the death but not resulting in the underlying cause given in Pert I.  Demenha - Al 2 luines  Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I.  1   Yes 2   No 3   Probably  24a. Was an autopsy performed?  25b. Was cese referred to medical examiner?  1   Yes 2   No 2	ury or	4 Donati	on 5 ☐ Other (	n 3.⊟R∈ ( <i>Specify)</i>	emovel from St	tate			10/01/0	O Crief	Fiold N	MD		
April   Apri		21 Signeture of	f Funeral Service	e License	e c		22	. Name end Addr		op cristieid, MD.				
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30. Name end eddress of person who completed cause of deeth (ttem 23a) (Type, Print)	edicai Certification: To Be Completed by Physician/Medical	Pert II. Other el  25. Was cese reaminer? 1 Yes  27. Manner of D 1 Naturel 2 Accider 3 Suicide 4 Homici  29a. Certifier (Check only one)	gnificent condit  De ry  No r  eferred to medical  No heeth  5   Pendi invest of Could de condit  1   Certifyi 2   Medical	tions continued from all	Prediction of the basis of the	Due to (c)  Due to (c)  Due to (c)  The purp to (c)  Due to (c)  Due to (c)  Due to (c)  The purp to (c)  Th	or es e consequence de consequence d	uence of):  uence	26. Piece of De her: Nursing layet of No. 2 No.	24a. Weiperfill  24a. Weiperfill  1	Yes 2 No s en eutopsy ormed?  Yes 2 No one) idence 6 Oth how Injury occur (Street end Numburn, State) ceuse(s) end me, date end place, 29d. Date signe	24b. Were e eveileb comple of deet!  1  Yei  Der or Rural Roten due to the ad (Month, Day,	utopsy finding: le prior to tition of ceuse h? s 2 \sum No  ute Number, l. ceuse(s)	

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 32640 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Year Soderberg 6:50 p.m. Robert William September 10,2000
4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not Institution, give street end number) 4c. County of Deeth Solomons Nursing Center Solomons Calvert Birthplece (State or Foreign Country) if Under 1 Year 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Deys Months Hours 1 M 2 □ F Yrs. 361-05-8586 Sept. 6, 1918 Illinois Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 PNo Maryland Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 111 William Street United States

14. Race - American Indien,
Bleck, White, etc. 20688 Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedenf Ever in U.S. Armed Forces? 11. Meritei Status 1 Yes 2 No If Yes, Give 1940 Yeer or Detes: 1067 1 Never Married 2 Married 1 ☐ Yes 2 ■ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 1967 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Commissioned Officer US Defense 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) William Evans Soderberg Winifred Hanlon 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Lee Norris Soderberg / Wife P.O. Box 1644, Solomons, Maryland 20688 20b. Place of Disposition (Neme of Place of Disposition (Neme or cemetery, cremetory or other place)
Crematory 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 Cremetion 3 ☐ Removel from Stete 9-12-00 Charlotte Hall, MD 4 Donetion 5 Other (Specify) Brinsfield-Echols 22. Neme end Address of Fecility Brinsfield Funeral Home, P.A. Edward N. Brinsfield. Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, and a proximate interval Between the shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final 5 mintes arry disease or condition resulting in death) Sequentially list conditions, if eny, teeding to immediate ceuse. Enter Underlying Cause (Disease or Injury thef Initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert f. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy 1 ☐ Yes 2 No 1 TYes 2 No. 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Manger of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending 1 Yes 2 No 2 Accident investigation

Physician /Medical Examiner burial-tran and physician Box 68760 the

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

P

Completed

Be 2

**Funeral** 

Director

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r than "natural", or items 23s or 28s-1 show

with the Maryland

death

filed within 72 hours aftar

al Hygiene.

Pages 1 and 2 should be fil tment of Haalth and Mantal H tant: If Item 27 Ia marked off lury or other traumatic ever

permit. Page Department in Important: If any Injury or

Maryland 21215-0020

altimore,

Examiner usa signed by the a peed certificate director, funeral I or Attending after death. Director: Aft

P.0.

Division of Vital

Physician/Medical by Completed Be To Certification:

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

State Registrar 29b. Signeture end title of certifier hanly in Bennett MD 29c. License number 125156 29d. Dete signed (Month, Dey, Year) September 11, 2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Charles W. Bennett, M.D., 11845 H.G. Trueman Road, Lusby, Maryland 20657 31. Dete filed (Month, Day, Year)

SEP 14 2000

6 ☐ Could not be

32. Registrer's Signeture

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

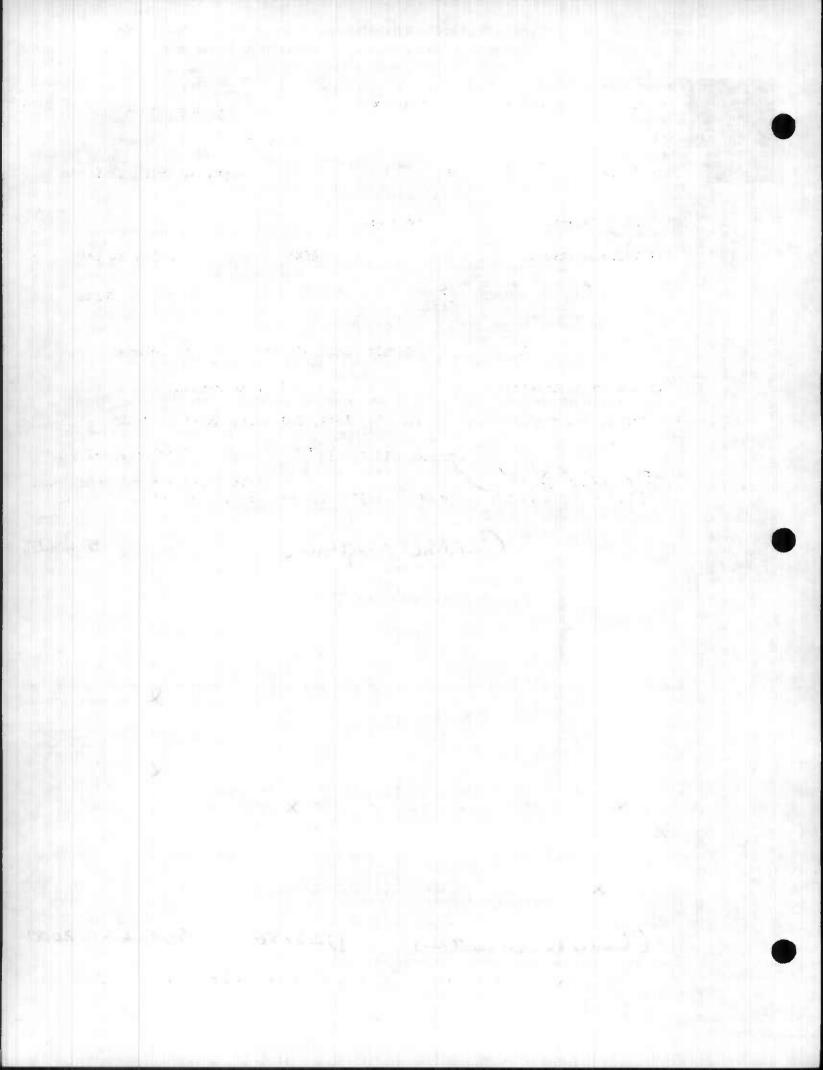
1 Xertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

24 hours

To the vithin 2

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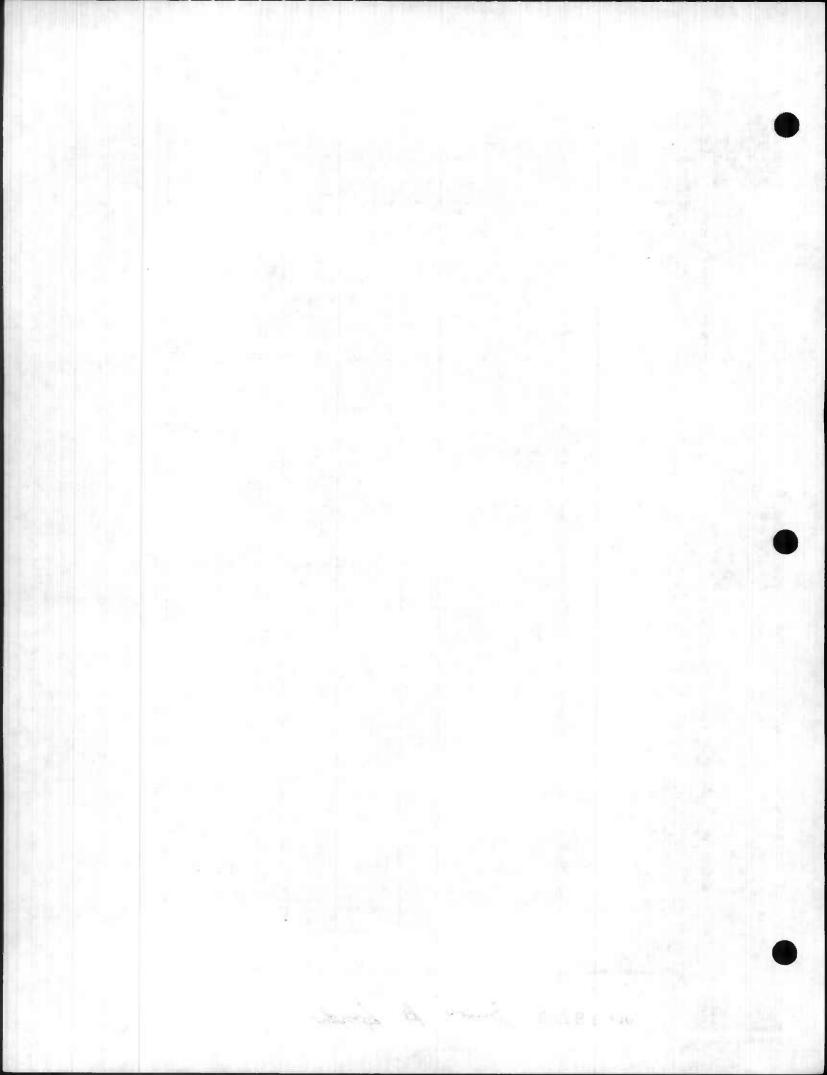


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State of Maryland / I	Department of H	ealth and Mental	Hygiene

		State of Maryla		artment of h		lental Hy	giene Reg. No.	00 3	2641					
	1. Decedent's Neme (First, Middle, Las.	1)				2. Dete of De	eth		3. Time of Deeth					
Physician /Medical	MARY ELIZABET	H SOMERVILLE				Septem	ber 9,	2000	2:00 AM					
Examiner	4e Facility Neme (If not institution, give	street end number)			4b. City, Town, or L	ocation of Deat		y of Death						
•	St. Mary's Nursin				Leonardt			t. Mary						
Funeral	5. Social Security Number 6. Se	7. Age (In yrs	ast birthday)	If Under 1 Yeer Months Days	If Under 24 Hrs. Hours Min.	(Month, De	th by, Year)	Country)						
Director	Usuet Residence of Decedent		86 Yrs.			10-15	-13	Leonai	rdtown, MI					
/land	10a. Stete 10b. County	10c. C	ity, Town or Lo	cation				10d.	Inside City Limits					
Man	Maryland St. Mar	v's	Lovevil	le				SE 18	YEWes 2□No					
vith the Ma to 2844 a be notified	10e. Streel and Number			10f. Zip Code			10g. Citizen of	What Country	7					
	40445 B. Somervil	le Lane			656		USA							
ifier death virtues 234	11. Marital Stalus	12. Was Decedent Ever in I Armed Forces?	U,S. 13.	Was Decedent of I If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	- 14. Ra Ble	ce - American eck, White, etc.						
urs afte	1 Never Married 2 Married  332 Widowed 4 Divorced	1 ☐ Yes 2∑Mo If Yes, Give		1□ Yes 2√1No	Specify:		Speci	b Black						
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Wents Wents rrked rtic a	Herbert Blackist	one	Rachel Swales											
d 2 should be file th and Mental Hy 7 Is marked othe traumatic avant	19a. Informant's Neme/Reletionship (T	ype, Print)	19b. Mailin	ng Address (Street	end Number or Ru	rai Route Numb	er, City or Town	n, Stete, Zip Co	ode)					
	Sarah Blackistone  26195 Loveville Rd, Mechanicsville, MD 20654  20e. Method of Disposition  20b. Place of Disposition (Name of cemetery, cremetory or other place)  20c. Location - City or Town, Stete													
00	20e. Method of Disposition  **Burial 2 Cremetion 3 🗆	Removel from State	cemetery, crei	metory or other ple										
t. Pa tman tant:	4 Donation 5 Other (Specify	1) St	y 9-14-00 Morganza, MD											
permit. Pages Department of Important: If it any injury or o	21. Signature of Funeral Savice Ucesh	- And	/	2. Name end Addre	St		ickland Funeral Services, Camp Springs, MD 20748							
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tal or Attending Prise after death.  al Director: After tied in by the funare Certification:	3 Suicide 6 Could not be determined	28e. Pleca of Injury - At building, etc. (Spec	home, farm, str	reet, factory, offica			Street end Nun wn, Stete)	nber or Rurel A	loute Number,					
Cer Cer		building, etc. (Specify)  City or Town, Stete)												
To the Hospital or Attending Physical Within 24 hours after death. To the Funeral Director, after this completely filled in by the funeral director Medical Certification: To	29a. Certifier Certifying Phy (Check only one)	eicien: To the best of my kn Iner: On the basis of examin	and due to the	cause(s) end n date and plece	nenner es state e, and due to th	ed. e ceuse(s)								
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5 3 7 8 m	C C ( /	u M.D												
	30 Name and address of parent visit	SCGaGy M.D. D54346 9-11-00  ne and eddress of person who completed cause of deeth (Item 23a) (Type, Print)												
90 DB	C. Sajja, M.D				lywood, N	AD								
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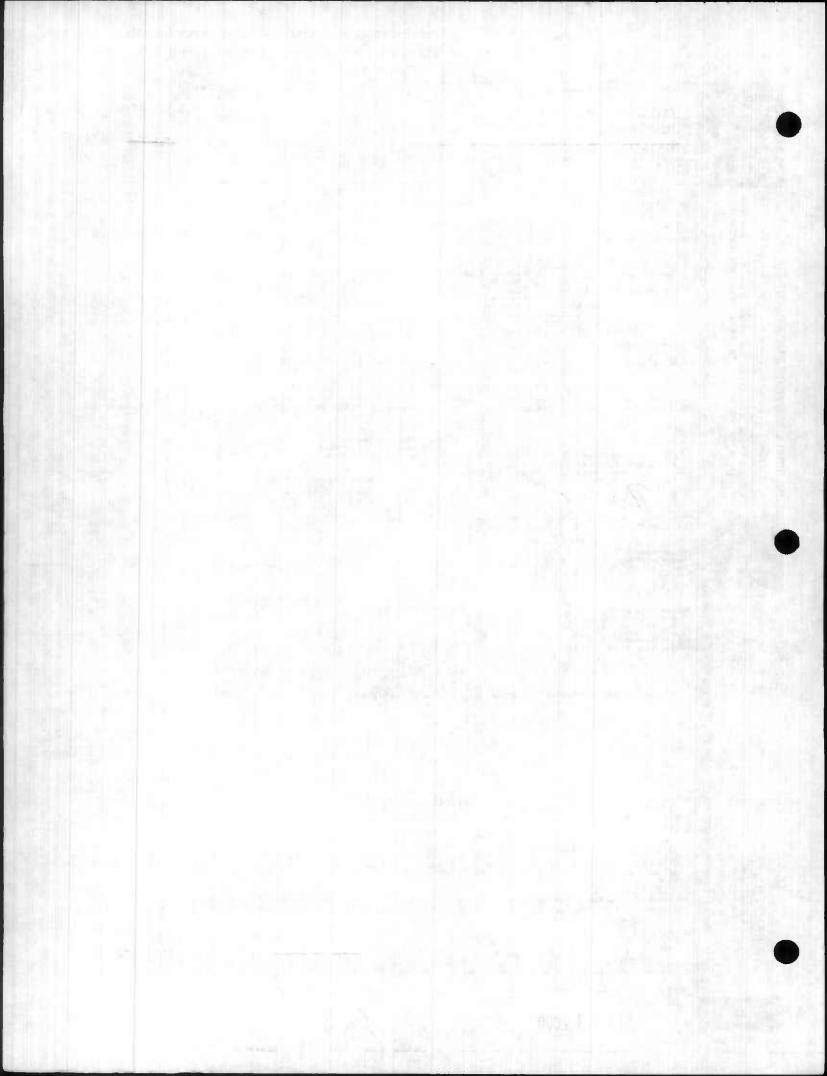
DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. 4a. Amended Items 4c & 29c State of Maryland / Department of Health and Mental Hygiene 32642 per Phy. 09/21/2000, Carroll County, wjl Certificate of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** 03:52 AM STULL 2000 09 ADDIE 8 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (I not institution give street and number Medical System Examiner BAUTIMORE CITY N/A UNIVERSETY HOSPITAL MARYLAND If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth Month Day, Year) 12/5/1902 Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 6. Sex **Funeral** Days Hours Min 1□ M 2 F 97 Yrs. 219-20-3378 Director MARYLAND Usual Residence of Decedant 10c. City, Town or Location 10d. fnslda City Limits 10a. Stata 10b. County Neme 23s or 28s-1 show 1 Yas 2 □ No Director WESTMINSTER MD. CARROLL the Medical Examiner must be notifi-10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code USA. 45 S. CHURCH ST. 21157 Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No ff Yas, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Bleck, Whita, atc. filed within 72 hours after 1 □ Navar Married 2 □ Married b Maryland 21215-0020 1 ☐ Yas 2 No Specify Specify: WHITE Á 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) HOME MAKER HOUSEWIFE 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Fathar's Name (First, Middle, Last) nd Mental Pages 1 and 2 should be ESTELLE BUXTON SYLVESTER WATKINS pue 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) . nt of Health: If Nem 27 is - DAUGHTER 441 BANKARD RD., WESTMINSTER, MD. 21158 LOIS FORD Baltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata ₩ Burial 2 Cramation 3 Ramoval from Stata 8 MEADOW BRANCH CEM. 9/20/00 WESTMINSTER, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Fecility FLETCHER FUNERAL HOME 21. Signatura of Funaral any in 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate intervel Betw Onsat and Death **Physician** fmmediata Ceusa (Final disaasa or condition rasulting in death) /Medical BILATERAL PLEURAL Examiner Dua to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Diseasa or injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of) Box 68760. the Dua to (or as a consequence of): US0 88 P.O. Part ff. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? detached 1 Yes 2 No 3 Probably 4 Unknown by of Vital Records, 99 24b. Wara autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? page 2 should Be Completed has 1 Yas 2 No 1 ☐ Yas 2 ☐ No this certificate or Attanding Physician: funeral director. 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) Hospital: 1' Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No Medical Certification: To 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Tima of Injury at Work? After Division Naturat 5 Pending after death. Director: Af 1 Yas 2 No invastigation 2 Accidant the 28f. Location (Street and Number or Rural Routa Number, City or Town, Stefa) 6 Could not be datarmined 3 Suicida 28a. Plece of Injury - At homa, farm, streat, factory, office building, alc. (Specify) filled in by 4 - Homicida To the Hospital of within 24 hours at To the Funeral D 29a Cartifia 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, data and placa, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at tha time, deta end place, and due to the cause(s) and mannar stated. completely 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P14666 MD 18/2000 30. Nama and address of person who completed causa of death (Itam 23a) (Type, Print) University of Maryland Medical System SACK GREENE ST S BALTIMORE, MA 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar 2000

DHMH 16 Rev 6/95



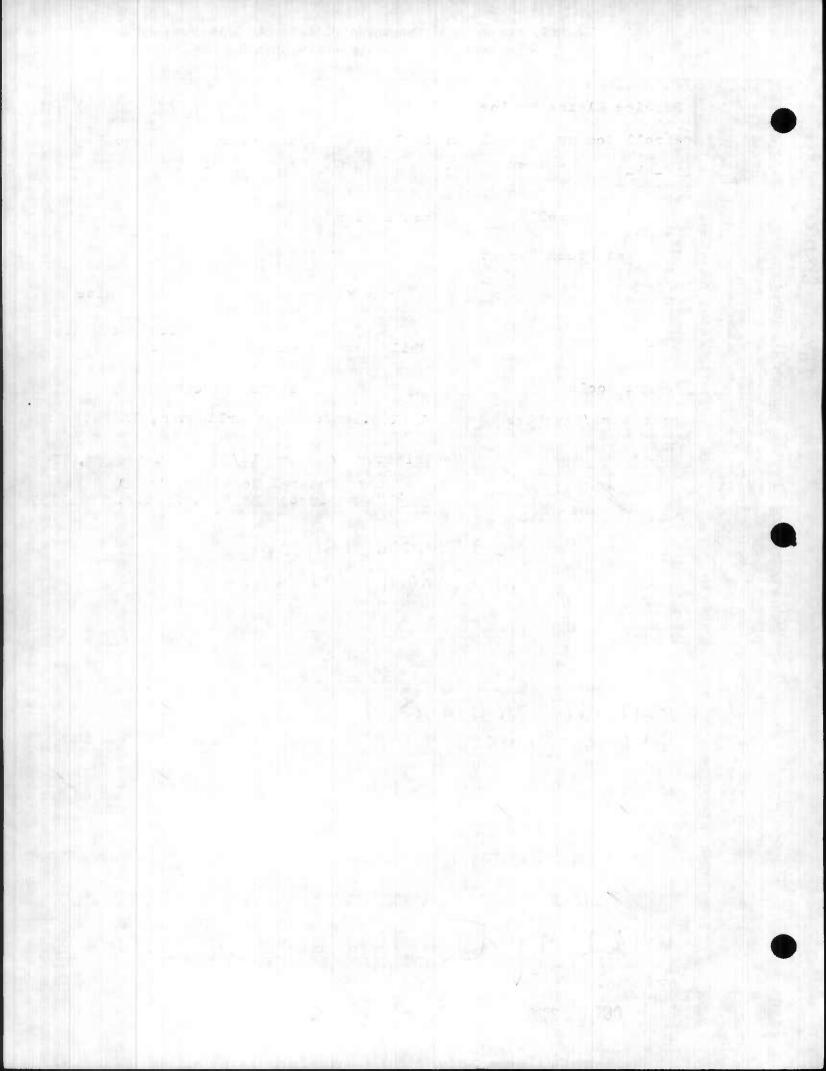
# TAYLOR, BERNICE

Please Type or Print In Black Indelible Ink.	. Assure All Copies Are Legible.
State of Maryland / Department of H	Health and Mental Hygiene
Certificate of	Death Reg. No.
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Physician /Medical	١.	Bernic			Taylo	r					2. Data of De Month	Di	) 'q	Year	3. Time	P.M
Examiner		la Facility Name (	If not institutio	n, giva st	reet and num	ber)			4	lb. City, Town, or L	ocation of Deat	th 40	c. County	of Death		
		Carroll	Count	cy G	enera	1 Hos	spital			Westmin				rrol:		
Funeral Director	1	5. Social Security N 213-24-	3993	6. Sex 1 □ I	M XIXF	'. Age (In yr:	s. last birthday) Yrs.	If Under 1 You Months Da		If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di Aug 1			9. Birthp Coun	lace (State try) MD	or Foraig
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permit. Pege Department of Important: if eny Injury or pace.		21. Signatura of Fi	unaral Service	Licensee	1		P		Fι	ss of Facility ineral   ington					MD 2:	1157
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or Attending Physicien: The law requires that the deeth cert bird deeth cert bird deeth cert bird deeth cert bird deeth cert at his certificate has been signed by the ettending in by the funeral director, page 2 should be detached for use entification: To Be Completed by Physician/N	no n	HYP	ENGL	40	emv	2					24a. Wa	s an automed?	opsy	av.	ere autops ailable prio mpletion o death?	rto
The law ite has bege 2 s	5										10	Yes :	No	10	Yes 2	No
entifica ector, p		25. Was case refer	red to medica	1						26. Place of Dea	th (Check only	one)			1	
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or Attending safer deeth. I Director: After d in by the fune		3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be nined	28e. Plece o buildin	ot Injury - At g, etc. (Spec	home, farm, str	eet, lactory, off	lica	11.41	28t. Location City or To	(Street a own, Sta	nd Numt te)	ber or Rure	I Route No	mber,
To the Hospital or Attending Physicien: The law within 24 hours aftar deeth. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	10000	29a. Certifier (Check only one)	Cortifying 2 Medical	ng Physic Examins	lan: To the b r: On the bas end manne	is of examin	nowledge, deeth	n occurred at the	e tin	ne, date and placa pinion, deeth occu	, and due to the rred et the time	cause( , date er	s) end mi	anner es si end due to	teted. the cause	n(s)
Tot Tot com		29b. Signature	lille of certifie	M	(45	1		MD		d 004 (	-		ate signe	Month,	Day, Year)	
	13	30. Name and addi	ess of person	who com	pleted cause					minster, al Hospit			2115 mori	al Av	e.	
State		31. Date tiled (Mon	th, Day, Year		32. Re	gietrar's Sign	natura									

Registrar

s Signatura & Sparks



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** September 29, 2000

4b. City, Town, or Location of Death

4c. County of Deeth Pauline Norman Taylor 11:50 PM /Medical 4a Facility Name (If not institution, give street and number) Examiner Citizens Nursing Home 5. Sociel Security Number 6. Sex 7. Age (1) Havre De Harford Grace If Under 1 Year 8. Dete of Birth (Month, Day, Year) 01/14/1905 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2XF Yes 215-40-0186 95 Maryland Director Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itema 23a or 28a-f show way fujury or other treumatic event, the Medical Eventual on the notified at each. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 738 Nottingham Drive 21001 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian Bleck, White, etc. 11. Meritel Slatus 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White P 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th Homemaker Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 10 Ernest Norman Annie Margaret Johnson 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Norma Burke- Daughter 738 Nottingham Dr., Aberdeen, MD 21001 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 X Burial 2 Cremetion 3 Removal from State Angel Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 110/3/00 Havre de Grace, MD 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Mitchell-Smith Funeral Home, P.A. YY 123 S. Washington, Havre de Grace, WD 21078 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner o Bromwhye Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760 94 Due to (or es a consequence of) Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of seath? P.O. 1 Yea 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed Memer 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Vital 25. Wes case refermed examiner? Be 26. Place of Deeth (Check only one) 1 yes 25 No Other: Nursing Home 5 Residenca 6 Other (Specify) 10 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 27. Mayiner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of Division 1. Neturel 5 Pending 1 Yes 2 No investig 2 Accident after deall Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide To the Hospital of within 24 hours a To the Funeral D 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License numbe 29d. Date signed (Month, Dey, Year) 29b. Signalius and title of certifie 3 10/2/ of person who completed cause of death (Item 23a) (Type, Print) Union

DHMH 16 Ray 6/95

Registrar

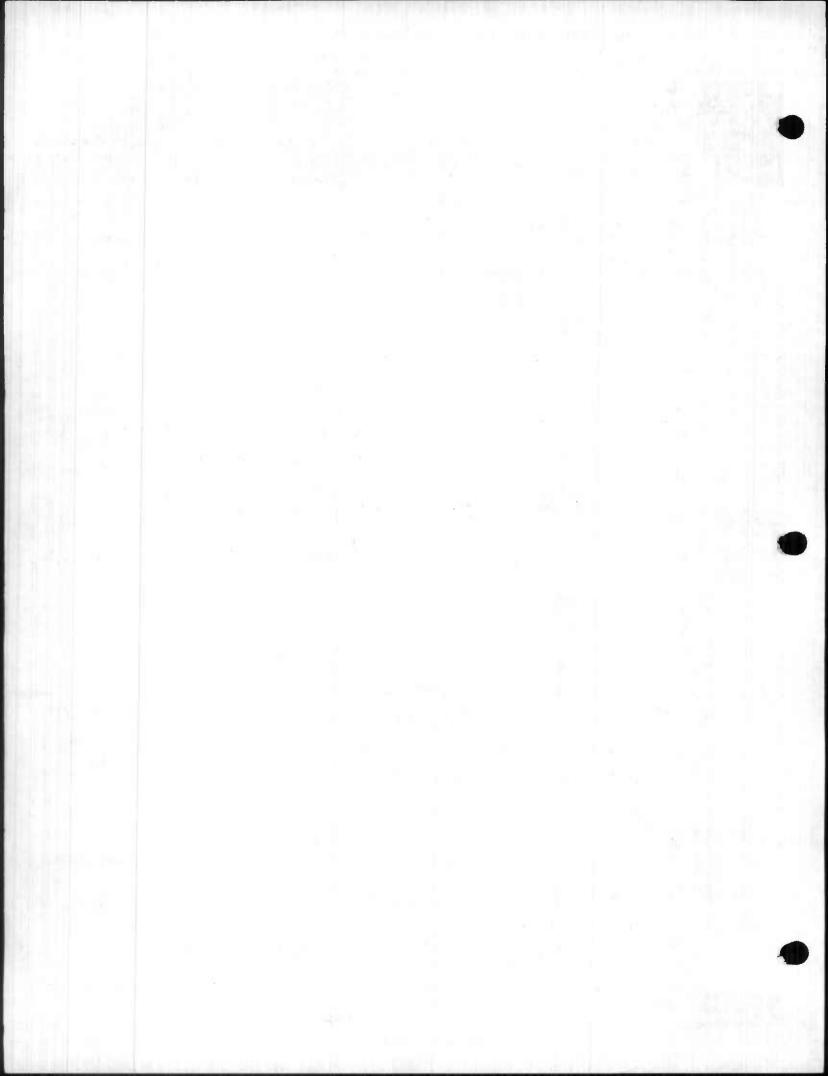
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- 2000

Pauline

32 Mogistrar's Signature

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Physic /Medi		1. Decedent's Na Be++	ame (First, Middle, La	edroi	ب					2. Date of D Month	Day Day	Yeer 2000	3. Time of Death
Examii Funeral		4a. Facility Name  Man  5. Social Security	Number 6.5	e s	Rossi	ille last birthday)	if Under 1	Year	Baltir Baltir If Under 24 Hrs.	B. Data of B	lirth 73	Balt	ince (State or Foreign
Director		Usual Residence	of Decedent	□M 2XF	7	19 Yrs.		Days	Hours Min.	03/1	2 Year)		place (Stata or Foreignty). Virginia
n the Marylan r 28a-f show	rector	MD  10e. Street and N		rford	10c. C	Abero		ode.			10g. Citizen of		10d. Inside City Limit
ter death with	by Funeral Director	11. Marital Status	urried 2/2 Married	12. Was Dac Armed Fo 1  Yas If Yes, Gi	2 MNo ve			21 ( nt of HI y Cuba	001 spanic Origin? (Sp n, Mexican, Puerto Specify:	acify Yas or N Rican, atc.)	U.S	ce - Amaric	can Indian,
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ould be filed Mental Hygi erked other	To Be C	17. Father's Nam	e (First, Middle, Last) is 0. Todd						18. Mother's Nam	e (First, Middl Courtr	a, Maidan Sumar		
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/Medical Examiner	er	Immediate Cause diseasa or condit resulting in death	tion	a. Ce	1000	or as a consec		F	Accide	int			7 days
requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the buriat-transit	Physician/Medical Examiner	Sequentially list of any, leading to ceusa. Enter Uni Cause (Disease that initiated ever resulting in deeth	Immediate derlying or Injury ots	b c		or as a conseq							
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a fee	Certification: To	1 Yes 30 27. Manner of De. 1 Naturel 2 Accident 3 Sulcide 4 Homicide	5 Pending investigation 6 Could not be	28a. Dete (Mon	of Injury th, Day Year)	28b. Time of injury	M 280	i Injury Work 1 □ \	4 Nursing Ho	28d. Describe	sidence 6 Otto	rred	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical Cer	29a. Certifier (Check only one) 29b. Signature ap	Certifying Ph	yelcian: To the	best of my kno	owledge, death	estigation, Ir	my op	e, dete end plece, inlon, deeth occur number	and due to the	cause(s) end m	end due to	the ceuse(s)
		30. Name end	an L Gre	In D			Print)		5992 Ave	Bilt	09/2	25/C	21323
Sta Registr	ite ar	31. Date filed (Mo	SEP 2 7 200	00 32/A	egistrar's Sign		Spa	Ms			1	111	



# Thoma Charlotte

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	State o	f Maryl	and / D	Departm	ent of H	ealth and	Me	ental Hyg	giene	000

32646 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month CHARLOTTE ELEANOR ESTEP THOMAS 2000 11:45 A.M. 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Civista Medical Center La Plata Charles If Under 1 Year | If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) FEB. 23, 1 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 1 M 2 F Months Days Hours Yrs. 1944 MARYLAND 56 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No CHARLES NEWBURG 10f. Zip Code 10g. Citizen of What Country?

20664

1 ☐ Yes 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PROGRAM COORDINATOR

20b. Place of Disposition (Neme of cemetery, cremetory or other place)

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

UNITED STATES

16b. Kind of Business/Industry

20c. Location - City or Town, State

18. Mothar's Name (First, Middle, Maiden Sumeme)

13535 PICCOWAXEN CREEK ROAD, NEWBURG, MARYLAND 20664

19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)

RUTH ELEANOR JOHNSON ESTEP

14 Race - Amarican Indian Bleck, White, etc.

BLACK

20640

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

10-2-2000

Approximate Interval Between Onset end Death

CHARLES COUNTY ASSN. OF

HANDICAP & RETARDATION

**Funeral** Director

**Physician** 

/Medical

Examiner

Directo

þ

5. Social Security Number

219-42-3652

MARYLAND

10e. Street and Number

10a. State

Usual Residence of Decedent

1 Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

Elamantary/Secondary (0-12)

CHARLES ESTEP

20a. Method of Disposition

17. Father's Neme (First, Middle, Last)

19a. informant's Name/Relationship (Type, Print)

JOHN HENRY THOMAS / HUSBAND

10b. County

13535 PICCOWAXEN CREEK ROAD

15. Decedent's Education (Specify only highest grade completed)

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 Ø No If Yes, Give Year or Dates:

Collega (1-4or 5+) 2YEARS

event, the Medical Exami merked

Pages 1 and 2 ment of Health an Department of Health a Important: If flem 27 is any injury or other tracents.

**Physician** /Medical Examiner

Examiner Physician/Medical 2 Completed Director: After this certific d in by the funeral director, Be Medical Certification: To death. filled in by or A To the Hospital within 24 hours a To the Funeral C

The law requires that the death certificate be execu

Box 68760

P.O.

of Vitai Records,

Division

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SHILOH CHURCH CEMETERY 10/6/00 NEWBURG, MARYLAND 21. Santara of Funaral Sarvice Licensee 22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A. THORNTON JOHNSON M00583 YOTA C. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in deeth) Last as a consequence of Part II. Other significant conditions coarributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1⊖Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 1 Yes 2 No 25. Wes case referred to medical 26. Piece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 5 Pending Investigation 1 Tyes 2 No 2 Accident 3 ☐ Suicide

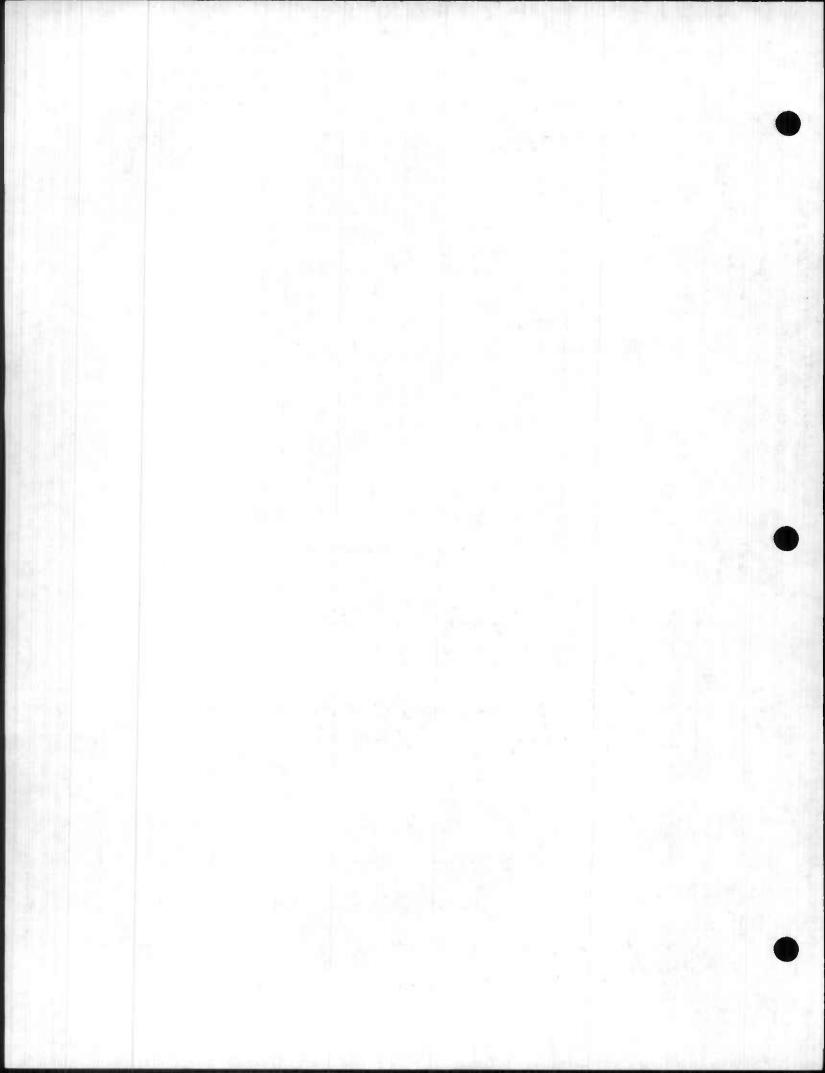
28d. Describe how injury occurred 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 6 Could not be determined 28e. Placa of Injury - At home, ferm, street, factory, offica building, atc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar (Check only one) 29th Olgrature and title of certif 29c. Licanse numbar 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul E. Pritchett, MD. 118 LaGrange Ave. P.O.Box 1317 La Plata, MD. 20646

State Registrar 31. Date filed (Month, Day, Year) OCT 0 5 2000 32. Registrar's Signatura

D - 0008370



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Dev Month Yee **Physician** Tichnell Nellie SEPTEMBER 27 2000 11:02AM /Medical 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Sacred Heart Hospital Cumberland Allegany 7. Age (In yrs. lest birthdey) If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Dey, Year) Nov. 4, 1910 9. Birthplece (State or Foreign Country) West Virginia **Funeral** Deys 10 M 2NE Months Hours 220-76-9177 Director West Usual Rasidence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show the Medical Examiner must be notified at MD. Garrett Swanton Director 1 Tyes XXX No 10e Street and Number 10f Zin Code 10a. Citizen of Whet Country? or Nerns 23a or 2151 Chestnut Grove Road 21561 USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Black, White, etc. 72 hours efter 1 Yas 2 No 1 ☐ Nevar Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0020 1 Yes XXNo Specify: à 3 Widowed 4 □ Divorced Year or Dates: "natural". Completed 16a. Decedent's Usuat Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health end Mentel Hyglene. Important: If Ifem 27 is marked other than any injury or other traumatic event. The many injury or other traumatic event. Elementery/Secondery (0-12) College (1-4or 5+) Housework Homemaker 18. Mother's Neme (First, Middle, Maiden Sumema) 17 Father's Name (First Middle Last) Be Arno1d Shreve Miranda Sears 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Jerry Tichnell/ son 16472 Maryland Highway, Swanton, Md. 20b. Plece of Disposition (Name of cematery, crematory or other plece) Tichnell Cemetery Dete 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 09/30/00 Swanton, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensea 22. Name end Address of Fecility Boal Funeral Home an ne 62 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Batween Onset end Deeth **Physician** MyoCARDIAL Infarction /Medical tmmediete Cause (Final Hours disease or condition resulting in deeth) Examiner Examiner Sequentially tist conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Disease or thjury that initiated events rasulting in death) Last end Due to (or es e consequence of): physicien e Box 68760. Physician/Medical Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 1 Yes 2 No 3 Probably 4 Unknown neumonia signed t p 24b. Were autopsy findings svaileble prior to complation of causa of deeth? Completed 24a. Wes en eutopsy performed? CONGESTIVE HEART FAILURE 2 1NO 1 ☐ Yes 2 ☐ No certificate Mospital or Attanding Physician: 24 hours after death. Funeral Director; After this certifica 25. Wes case referred to medical examiner? Be 26. Placa of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 2 Inpatient 2 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b Time of 28c. tnjury at Work? Certification: 1 Neturel 5 Pending investigation 1 Tyes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Pteca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) within 2 \$ 29b. Signature and title of certifian 29c. License number 29d. Dete signed (Month, Day, Year) 0 getember 30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)

Registrar

State

SAZURNENA

31. Dete filed (Month, Dey, Year)

CHANG

10701 New Lengs Creek

32. Registrer's Signetura

S.W. Suite 3

Frontburg Mary Jan 21532



State of Maryland / Department of Health and Mental Hygiene

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	Examin	ei									M			11	C.	M		
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	Funeral	10	5. Social Security Number	6.	Sex 1 M 2 □ F	7. Age (	In yrs. last birti	rs.	Months	Days	Hours	Min.	8. Date of B (Month, D	ley, Year)		9. Birthpie	ry)	te or Foreign
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			William Boyd	II,	25365	Point	Looko	ut ]	Road	. Le	onard	town	, Mary	land	206	50		-
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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 20, 2000 7:40 p.m. Alice Joanne Umbel 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Garrett County Memorial Hospital Oakland ff Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) Days Hours 1 □ M 2 1 F Yrs. 215-44-9010 53 Dec 9, 1946 Pennsylvania Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. fnside City Limits 1 ☐ Yes 2 No Garrett Oakland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4687 Oakland-Sang Run Road 21550 USA 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 th Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sum 17. Father's Name (First, Middle, Last) Dallas A. Durst Beulah E. Hare 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Richard Umbel/husband 4687 Oakland-Sang Run Rd., Oakland, MD 21550 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Steele Cemetery, Sept 23, 2000 Friendsville, MD 22. Name and Address of Facility Newman Funeral Homes, P.A., PO Box 275 21. Signature of Funeral Service License 179 Miller St., Grantsville, MD nter the mode of dying, such as cerdiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or hear tailure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Azcident Cerebrovascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No Circhosis Obstructive Lung Diserse 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

**Physician** /Medical Examiner that the death certificete be execu

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Mod cal Examiner must be notified at

Peges 1 end 2 should be filed within 72 hours atternent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite
Ity or other traumatic event, the Mod all Entities.
Ity or other traumatic event, the Mod all Entities.

permit. Pege Department o Important: If any injury or

Baltimore, Maryland 21215-0020

the Maryland

death

Examiner ician end burial-transit physiciar the 98 page 2

signed by the funeral deeth. 24 hours after deet Funeral Director: To the Hosp within 24 hou To the Fune completely fil

Division of Vital Records, P.O. Box 68760.

Hospital or Attending Physician:

1 Yes 2 No

4 Homicide

29a. Certifier

Physiclan/Medicai þ Completed Be 0 Certification: 2 Accident 3 Suicide

25. Was cese referred to medical examiner? 27. Menner of Deeth

Hospital:

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Impatient 2☐ ER/Outpatient 3☐ DOA 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

The cartifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) and manner es stated.

| Medicel Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signeture end title of certifier

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

SCHWALM KARL

31. Date filed (Month, Dey, Year) SEP 2 5 2000 32. Registrer's Signeture

N. 4th ST. DAKLAND, MD

State Registrar

Medical

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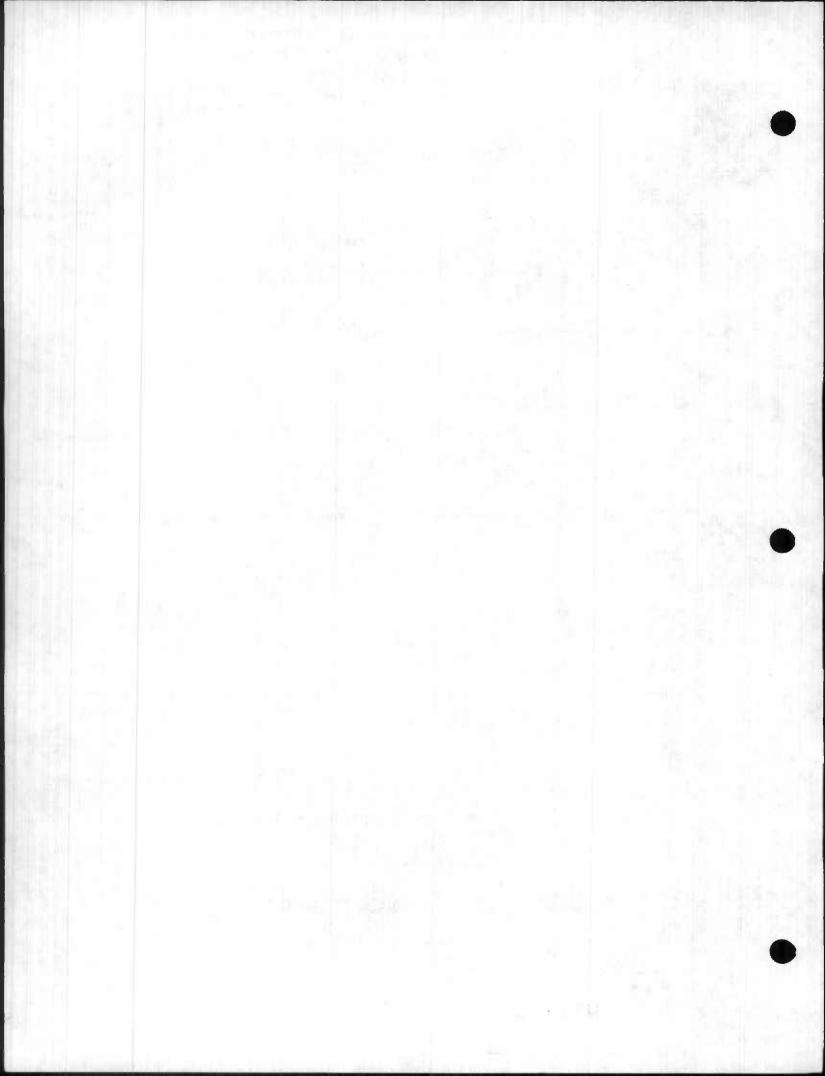
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22. Name and Address of Facility Schrimmer Funeral Home Tinc. 3331 Brehms Lane, Baltimone, Maryland 21213 23a-feft, Enter the diseased of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate individual or respiratory arrest.   Approximate individual or respiratory arrest.								10 /	00/00	Dan+iw	icho Habii				
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VLACH

JOSEPH



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** BARBARA LOGAN WOLF Sept. 23, 2000 5:45 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holly Hill Manor Nursing Home Towson Baltimore tf Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1 M 2 K Yrs 212-22-2654 Director 14/192 New York Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Baltimore Baltimore MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8314 Nunley Drive 21234 U.S.A. Apt. F death v Funeral 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify. þ 3 ☐ Widowed 4 ☑ Divorced Specify: Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Home other treumatic event, permit. Pages 1 and 2 should be file Department of Health end Mentel Hy important: If them 27 is marked other any injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Hugh Logan Lettie Linton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 21084 19a. Informant's Name/Relationship (Type, Print) Michael L. Desaulniers/Son 2319 Northcliff Drive Jarrettsville, Md. 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cematary, crematory or other place) 20c. Location - City or Town, Stata 2000 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland 23a. Part1. Enter the disease, or complications that caused the fishth. shock, or heart failure. List only one cause on each lina. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in daath) /Medical Hizheimers ears **Examiner** Physician/Medical Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Causa (Disaase or Injury that initiated evants resulting in death) Last pue Due to (or as a consequence of): for usa as tha burial-trar Division of Vital Records, P.O. Box 68760, physician Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? detached been signed by should be detec 3 Probably 4 Unknown 1 Yee 2 No þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? pege 2 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, Be 25. Was case raferred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 ANatural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation death. 1 Yes 2 No 2 Accident after death 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital To the Hospital within 24 hours a To the Funerel D 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier compietely 29d. Date signed (Month, Day, Year) 29b. Signatu 29c. License number who completed cause of death (Item 23a) (Type, Print) St. 38 Lutherville MO21093 York M 1205 Registrar's Signature State Registrar

DHMH 16 Rev 6/95

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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Re	g. No.	32652
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Physician /Medical	GARET ELLIS WINANTS JR.	Sept.	23, 200	9 ?unk
Examiner	4a Facility Name (If not institution, give street and number)  4b. City, Town, or Local	tion of Death	4c. County of Dea	th
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Funeral	Months Dave House Min	. Date of Birth (Month, Day,	Year) 9. Bit	thplace (State or Foreignantry)
Director	216-28-0822 - 75	10/29/		
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physician and s the bunal-transit edical Examiner	b	nea		year
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signed by the attendin d be detached for use d by Physician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
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# F	4 ☐ Homicide building, etc. (Specify)	City or Town		
the Funer pletely fill	29a. Certifier  (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and check only one)  13 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and check only one)  14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and check only one)	at the time, da	te and place, and du	e to the cause(s)
within 24 hours To the Funeral completely filled Medical Ce	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Mon	th, Day, Year)
	1 Mul Skylen / P1915	5	9/251	00
10	30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)  NAICK S (CAPURN MD) 1 16921 YORK NU	Mon	KION 1	nd 2111
State Registrar	31. Data filed (Month, Dey, Year)  SFP 2 6 2000  32. Registrar's Signatura			

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** Month 2000 4, B. Walters Oct. 1:03PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 119 Carolyn Avenue Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 11/20/1931 5. Sociel Security Number 9. Birthplece (Stete or Foreign Country)
Maryland 7. Age (In yrs. last birthday) **Funeral** Deys 1 MM 2□ F Yrs. 220-28-2086 68 Director Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show 1 Yes 2 No Director Somerset Deal Island 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Edelyn Webster Road 21821 USA Completed by Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Status Yes 2 No Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 € Divorced White the Medical 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver none Seafood marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Willie Walters Addie Bedsworth 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 69 or other trains 119 Carolyn Ave., Salisbury, Md. William Walters/Brother 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Burlal 2 Cremetion 3 Removal from State St. Peters U.M. Cemetery 10/7/00 Oriole, Md. 4 ☐ Donetion 5 ☐ Other (Specify) Signature of Funeral Service Licenses .22. Name end Address of Facility. Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, Md. 21853 3a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in death) Examiner the burial-transit Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Physician/Medical Due to (or es e consequence of): usa as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? cate has been signed by page 2 should be detac 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 1 Yes 20 No 1 ☐ Yes diractor. Be 25. Was cese referred to medice 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpetient 3 DOA the funeral 27. Menner of Deeth Certification: 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending Investigation 1 Naturel s after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

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Registrar

State

31. Date filed (Month, Day, Year)

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32. Registrer's Signature

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illed within 72 hours after death

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Baltimore, Maryland

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The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

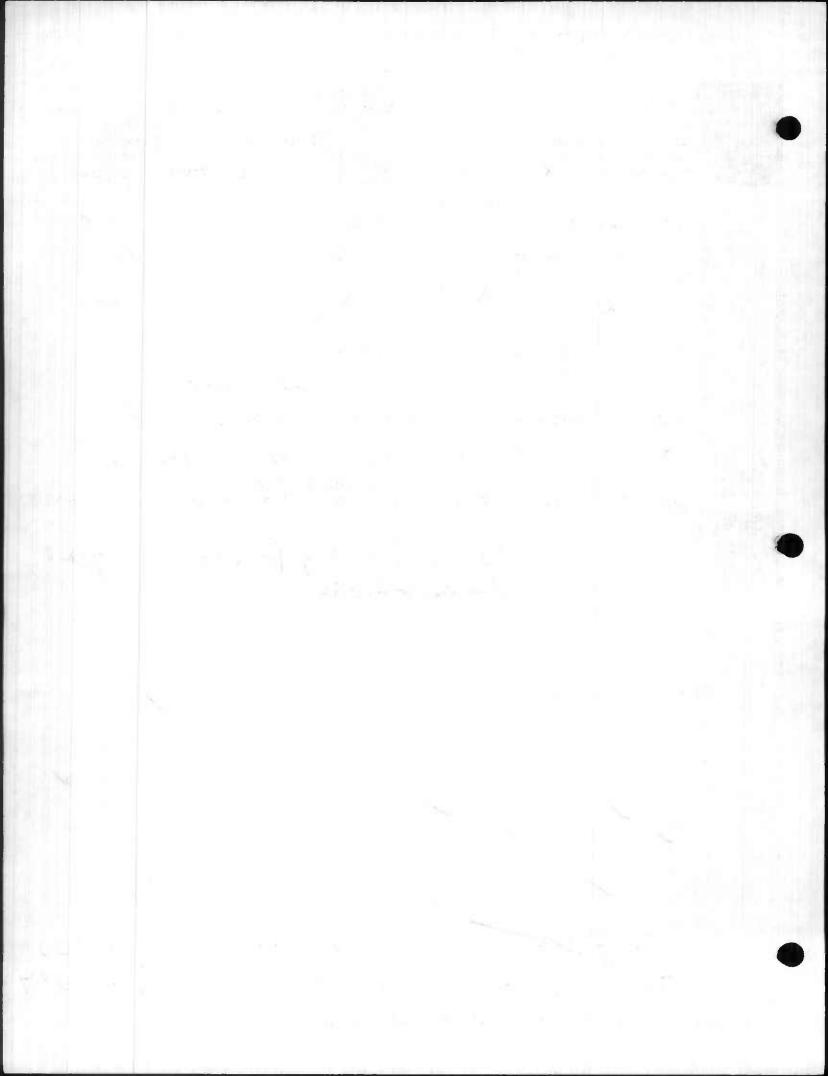
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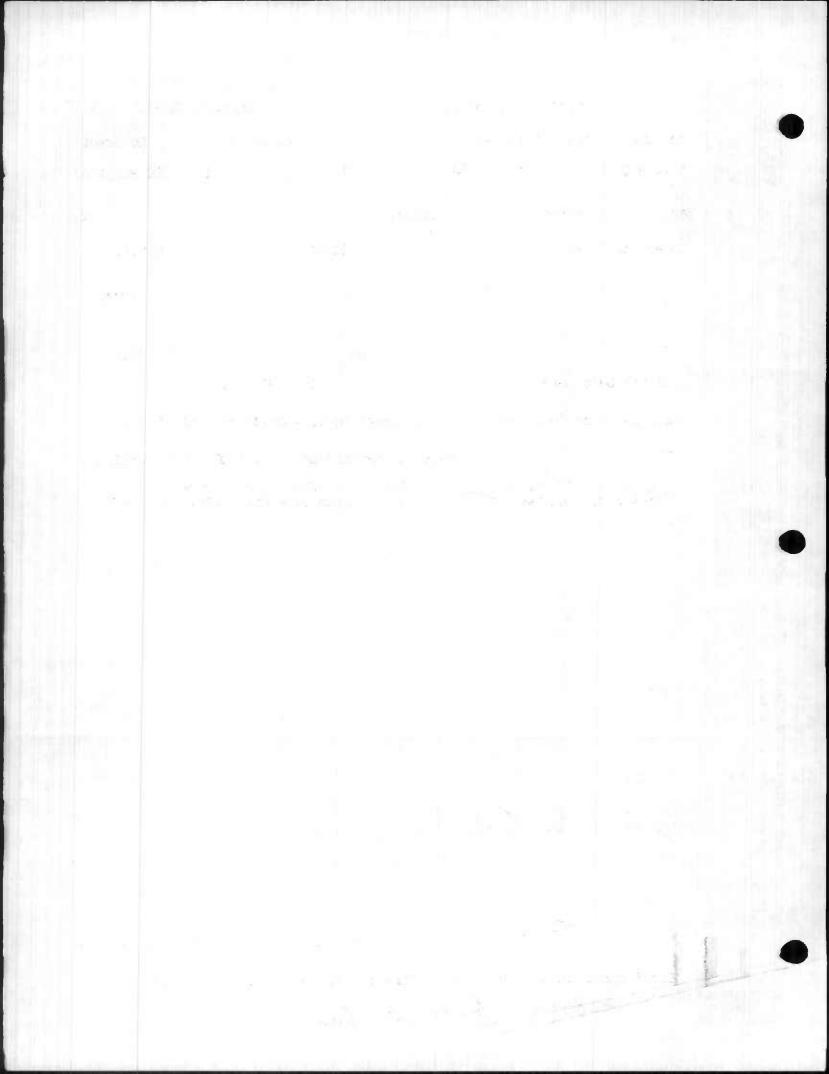
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State of Maryland / Department of Health and Mental Hygiene

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ToB		Albert Larrimo	re				Vina H	Hignutt			
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State Registrar 29b. Signeture end title of certifier

31. Data filed (Month, Day, Year)

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30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print) Powler

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32. Registrar's Signature

**DHMH 16 Rev 6/95** 

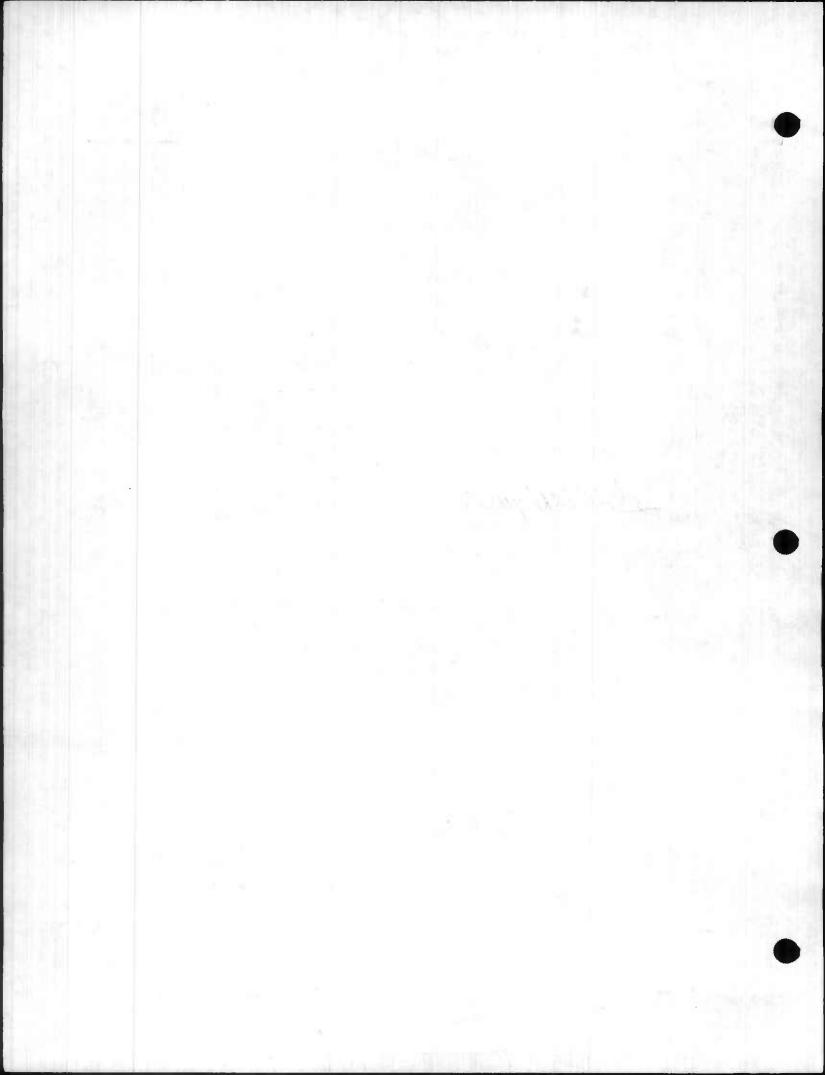
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29c. License number OCME

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Dey, Year)

SEPTEMBER 09, 2000

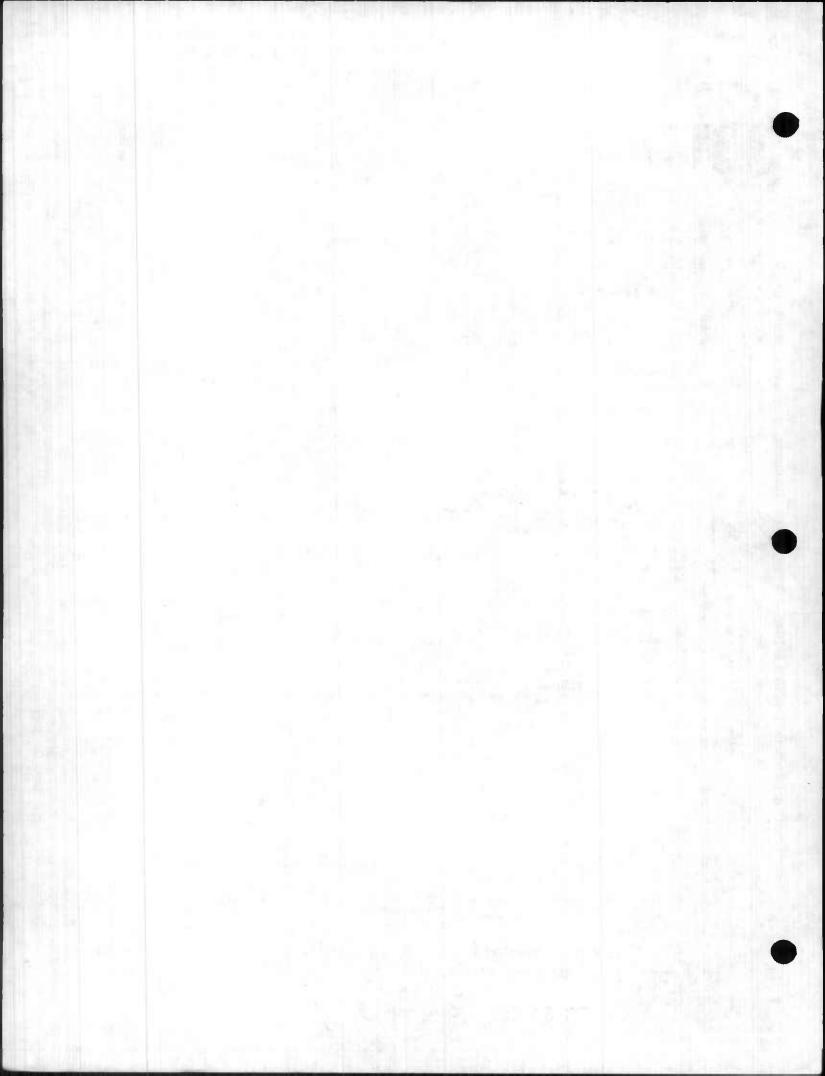


	1. Decedent's Nama (First, Middla, Last)	Reg 2. Data of Death	J. No. UU	3 2 6 5 6 3. Time of Death
Physician	Charles Willey	Month 9	7.8 Yaar	9:50 pm
/Medical Examiner	4a Facility Nama (If not institution, give street and number)  VA Medical Center  Baltimore		4c. County of Death	1
Funeral Director		8. Data of Birth (Month, Day, ) April 27		nplaca (Stata or Foraign unitry) cyland
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ther death with the Main there are size or stant as infilled informatible motified. Furneral Director	10e. Street and Number 10f. Zip Code 21669	100	g. Citizen of What Co	untry?
5-0020 72 hours after des neutral, or herrs after Examiner m	11. Marital Status  1 Nevar Married 2 Married 3 Widowed Widowed Widoword Narror Datas: Korea  12. Was Decedent Evar in U,S. Armed Forcas?  13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto fires, Giva Yaar or Datas: Korea	ecify Yes or No- Rican, atc.)	14. Raca - Amar Black, White Specify: W	
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ylar ouid b Menta mile e	Elmer Willey Fann	ie Horse		
Mar d2 sb d2 sb d2 sb d2 sb d2 sb d2 sb	19a. Informant's Name/Ratationship (Type, Print)  Thomas L. Willey Son  P.O. Box 14 Taylors T			
Baltimore, semit. Pages 1 an begaringet of Heat mportant. If Heat my injury or other	20a. Mathod of Disposition  20b. Place of Disposition (Nama of cematary, crematory or other place)	Data 20	aryland 21 Oc. Location - City or	Town, Stata
Baltin pamit, P Departme Important any injury ance.	21. Synature of Funaral Sarvice Limites  22. Name and Addrass of Facility  Thomas Funeral Home	10-3-00   e. P.A.	Hurlock,	Maryland
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Examiner	Immediata Causa (Final disaasa or condition rasulting in daath)  a. Acute Myccardial IV.  Dua to (or as a consequence of):  Coronary Artery I	CARSI		
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To the Hospital of within 24 hours a To the Funeral Completely filled	29a. Certifiar (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, (Check only one)  13 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and manner stated.			
To the within 2 To the comple	29b. Signatura and titla of certifiar  Resident Physician  29c. License number  P12381		d. Data signed (Montl) 9/28/	100
	30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)  A IEX Chodnovsky M.D. ID North Grane So	trect B	Saltimore, 1	ND 21201
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State of Maryland / Department of Health and Mental Hygiene

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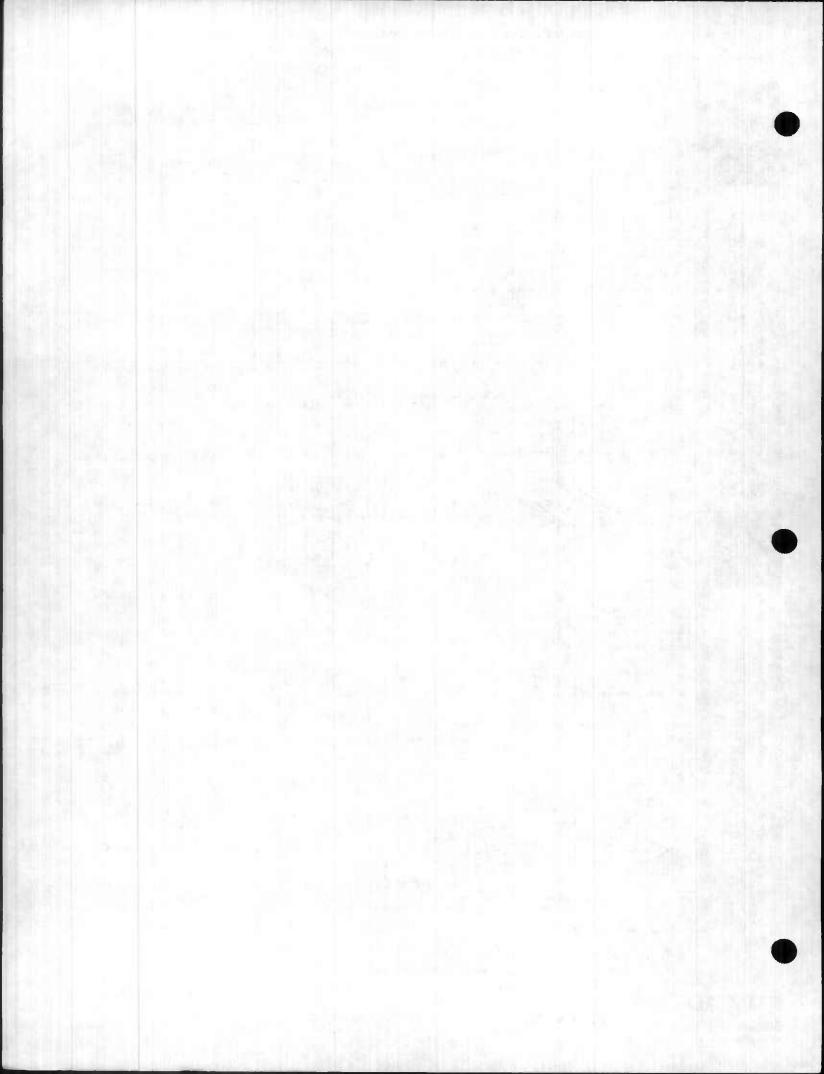
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ANNE ARUNDEL MEDICAL CENTER  5. Social Security Number  481-56-6215  Usuel Residence of Decedent  10a. Stete  10b. County  MD  QUEEN ANNE S  10b. Street and Number  419 LOVE POINT ROAD  11. Meritel Stetus  11 Never Married 2XMarried  31 Never Married 2XMarried  31 Never Married 2XMarried  15. Decedent's Education  (Specify only highest grade completed)  Elementary/Secondary (0-12)  12 College (1-4or 5+)  12 17. Father's Neme (First, Middle, Last)  OMAR BACON  19e. Informent's Name/Relationship (Type, Print)  PAUL W. WILDERSON, III/ HUSBAND  19b. Meiling Address (Street and Numb  PAUL W. WILDERSON, III/ HUSBAND  19b. Meiling Address (Street and Numb  PAUL W. WILDERSON, III/ HUSBAND  10b. Meiling Address (Street and Numb  PAUL W. WILDERSON, III/ HUSBAND  10b. Meiling Address (Street and Numb  PAUL W. WILDERSON, III/ HUSBAND  10b. Meiling Address (Street and Numb  PAUL W. WILDERSON, III/ HUSBAND  10b. Meiling Address (Street and Numb  10b. Meiling Address (Street and Numb  10b. Meiling Address (Street and Numb  11 Dove POINT ROA)  20c. Plece of Disposition (Neme of completed)  21. Signature of Funeral Sayvice Licensee  22a. Name and Address of Fecility  22b. Name and Address of Fecility  22c. Name and Address of Fecility  22c. Name and Address of Fecility  22d. Name and Address of Fecility  22	SEPT.  S. Dete of B. (Month, E. SEPT.)  SEPT.  Of (Specify Yea or Noverto Rican, etc.)  If working  S. Name (First, Middle DRED VOG.)  ORED VOG.  OF Rural Route Num.  STEVENS.  Dete  R. 9-27-20	ANNE A  Jay, Year) 21,1945  10g. Citizen of Wh  USA  No-  14. Reca Bleck, Specify:  16b. Kind of Busi  LITERAH  Je, Maiden Sumeme, ES  Nober, City or Town, S  VILLE, MD  20c. Location - C	ARUNDEL  9. Birthplece (Stete or Foreign Country)  SOUTH DAKOTA  10d. Inside City Limits 1 Yes 2 No net Country?  American Indien, White, etc. WHITE iness/Industry  RY  10d. Inside City Limits 1 Yes 2 No net Country?  American Indien, White, etc. WHITE iness/Industry  RY  10d. Inside City Limits 1 Yes 2 No net Country?							
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11. Meritel Stetus   12. Was Decedent Ever in U.S.   13. Wes Decedent of Hispanic Or If Yes, specify Cuban, Mexical   1   Yes   2   2   2   2   1   Yes   2   2   2   2   2   2   2   2   2	Name (First, Middle) RED VOG OF Rural Route Num STEVENS' Dete R 9-27-20	USA  14. Reca Bleck, Specify:  16b. Kind of Busi  LITERAF  Ie, Maiden Sumeme, ES  Nber, City or Town, S  VILLE, MD  20c. Location - C  000 STEVE	American Indien, White, etc. WHITE iness/Industry  RY  Intele, Zip Code) 21666 Eity or Town, Stele ENSVILLE, MD							
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1   Never Married   2   Married   3   Widowed   1   Divorced   1   Yes   2   No   If Yes, Give Year or Detes:   1   Yes   2   2   No   Yes   1	Name (First, Middle) RED VOG OF Rural Route Num STEVENS' Dete R 9-27-20	Specify:  16b. Kind of Business  LITERANE  I.E. Maiden Sumeme,  ES  Aber, City or Town, S  VILLE, MD  20c. Location - C  000 STEVE	WHITE iness/Industry  RY  itele, Zip Code) 21666 ity or Town, Stete CNSVILLE, MD							
15. Decedent's Education (Specify only highest grade completed)   16e. Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired)   17. Father's Neme (First, Middle, Last)   18. Mother OMAR BACON   18. Mother OMAR BACON   19. Informent's Name/Reletionship (Type, Print)   19. Meiling Address (Street end Numb PAUL W. WILDERSON, III/ HUSBAND   19b. Meiling Address (Street end Numb PAUL W. WILDERSON, III/ HUSBAND   19b. Meiling Address (Street end Numb Omath of Disposition (Name of Complete)   1	S Name (First, Middle) ORED VOG OF Rural Route Num OF STEVENS Dete R 9-27-20	LITERAL  Ie, Maiden Sumeme, ES  Aber, City or Town, S  VILLE, MD  20c. Location - C  000 STEVE	iness/Industry RY  State, Zip Code) 21666 Sity or Town, State CNSVILLE, MD							
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17. Father's Name (First, Middle, Last)  OMAR BACON  19e. Informent's Name/Reletionship (Type, Print) PAUL W. WILDERSON, III/ HUSBAND  19b. Meiling Address (Street end Numb 419 Love Point Roal 20c. Method of Disposition  1 Burlal 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify)  20e. Method of Disposition  1 Burlal 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify)  21. Signature of Funeral Service Licenses  22. Name and Address of Fecili FELLOWS, HELFEN 106 SHAMROCK RO.  23a. Pert 1. Enter the disease, or complicetions that saused the deeth. Do not enter the mode of dying, such as shock, or heart failure. List only one cause or each line.  Immediate Cause (Finel disease or conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that milited events resulting in death) Lest  Due to (or as a consequence of):  Due to (or as e consequence of):  Due to (or as e consequence of):	S Name (First, Middle) ORED VOG OF Rural Route Num OF STEVENS Dete R 9-27-20	le, Maiden Sumeme, ES aber, City or Town, S VILLE, MD 20c. Location - C	itete, Zip Code) 21666 ity or Town, Stele							
12 11 WRITER/ EDITOR  17. Father's Neme (First, Middle, Last) OMAR BACON  19e. Informent's Name/Reletionship (Type, Print) PAUL W. WILDERSON, III/ HUSBAND 20e. Method of Disposition 1 Burial 2 Dicremetion 3 Removel from Stete 4 Donetion 5 Other (Specify)  21. Signature of Fuperal Service Licenses 22. Name and Address of Fecility FELLOWS, HELFEN 106 SHAMROCK RO.  23a. Pert 1. Enter the disease, for complicetions that baused the deeth. Do not enter the mode of dying, such essabock, or heart failure. List only one cause of each line.  Immediate Cause (Finel disease or condition resulting in deeth)  Due to (or as a consequence of):  b. Due to (or as a consequence of):  d. Due to (or as e consequenca of):	ORED VOGI or Rural Route Num , STEVENS Dete	le, Maiden Sumeme, ES aber, City or Town, S VILLE, MD 20c. Location - C	itete, Zip Code) 21666 ity or Town, Stele							
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that infleted events resulting in death) Lest  Due to (or as e consequenca of):										
d										
Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert										
	23b. DI	d tobacco use cont	ributs to the cause of death?							
	10	Yes 20 No :	3 Probably 4 Unknow							
		9								
	24e. We	es en eutopsy rformed?	24b. Were autopsy findings eveileble prior to							
	- 13 m		completion of cause of death?							
	10	Yes 2 No	1 ☐ Yes 2 ☐ No							
25. Wes case referred to medical 26. Plec		y one)								
examiner?  1  Yes 2 No	f Deeth (Check only	sidenca 6 Other	(Specify)							
27. Menner of Death 28e. Dete of Injury 28b. Time of 28c. Injury at		e how injury occurre	d							
Naturel 5 Pending (Month, Dey Year) Injury Work?  2 Accident Investigation M 1 Yes 2	ing Home 5□Re									
3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, factory, offica	ing Home 5 ☐ Re 28d. Describ	28f. Location (Street and Number or Rural Route Number								
27. Menper of Death   Naturel   5   Pending   New Year   Sign   S										
29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date or	ing Home 5 Re 28d. Describ									
(Check only ane)  2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, decared and menner steted.	28d. Describ  28f. Location City or 7	own, Stete) ne ceuse(s) and man								
29b. Signature and title of cartifler 29c. License number	28d. Describ  28f. Location City or 7	own, Stete) ne ceuse(s) and man								
> 7 Delouisio 01983	28d. Describ  28f. Location City or 7	own, Stete)  ne ceuse(s) and man e, date end placa, er								
30. Name and eddress of person who completed cause of deeth (Item 23s) (Type, Print)	28d. Describ  28f. Location City or 7	own, Stete)  ne ceuse(s) and man e, date end placa, er	nd due to the cause(s)							
STRUTE COLONICU 900 BRITAGE	28d. Describ  28f. Location City or 7	own, Stete)  ne ceuse(s) and man e, date end placa, er	nd due to the cause(s)							
31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture	28d. Describ  28f. Location City or 7	own, Stete)  ne ceuse(s) and man e, date end placa, er	nd due to the cause(s)							



State of Maryland / Department of Health and Mental Hygiene

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Physician /Medical	Lis	a Mi	chelle	Wad	de					Septem	ber 20		8:23 F	P.M
Examiner	The state of the s	If not institution, giv		er)			- 4	b. City, To	wn, or Lo	cation of Deat	h 4c. Cou	inty of Deeth		
		aryland H			10.5				min			rrett	BLUCE.	
Funeral Director	5. Social Security N 216-08-8	559	Sax 7. □ M 2KDXF	Age (In yrs. la 15	rst birthday) Yrs.	If Under 1 Months	Days	If Undar Hours	Min.	8. Data of Bir (Month, Di Apr. 2	2, 198!	9. Birth	place (State or F ntry) yland	Forei
9 *	Usuel Residence of	Decedent 10b. County		10c City	Town or Lo	eation							10d. Inside City	Limit
a Maryla la-f sho diffed at ctor	MD	Garrett			wantor								1 ☐ Yes 2	
her death with the Maryla here 23s or 28s-f short ther must be postflied at Furneral Director		mber Maryland	Highway			10f. Zip C	oda 156	1				of What Cou d Stat		
Exam Exam by 9	3 ☐ Widowed	iad 2 ☐ Married 4 ☐ Divorced	12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑No If Yes, Giva Year or Dates:			13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexicen, Puerto			ecify Yes or No Rican, etc.)	14. Race - Amaricen Indian Black, White, etc. Specify: White		etc.		
72 h	(Spe	15. Decedent's E			(Giva	dent's Usual kind of work	done d	durina mos	t of work	ina	16b. Kind o	of Business/In	ndustry	
ad within 72 ho ypiena. wer than *natura, it, the Medical.	Elementary/Seco	ondery (0-12)	College (1-4d	or 5+)	life.	DO NOT use	retired	)						
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as that the deeth cer gned by the attendir be detached for use by Physiclary		ficant conditions of	ontributing to death	T DUI HOL TOSUI	ung m me u	ndenying cer	use giv	en in Parci			Y == 20 N			
been s should											s an autopsy ormed?	ar	Vere eutopsy fin- vailable prior to ompletion of cau f death?	
The law page 2										1/2	Yes 2 N	10 1,	Yes 2 N	Vo
certificate rector, pag	25. Was case refe	red to medical					-	26. Place	e of Deat	h (Check only	one)			
Physician: The I this certificate he rai director, page TO Be Com	examiner?	No	Hospital: 1 Inpa	atient 2 E	R/Outpatier	nt 3 DOA	Oth	er: 4 Nu	ursing Ho	me 5 Res	idence 6 🔽	Other (Speci	ify) at so	non
E E B	27. Manner of Deal 1 Natural Accident	th 5 Pending investigatio		Ony Your)	28b. Time or Injury	f 28	c. fnjur Wor	y at k? Yes	No	28d. Describe	how injury oc	courred	thiel	112
To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification: "	3 Suicide 4 Homicide	6 Could not be determined	e 286. Place of	Injury - At honetc. (Specify)	ne, farm, str	reet, factory,			7	28f. Location City or To	(Street and Ni	umber or Run	ral Round Number	ier,
To the Hospital within 24 hours within 24 hours Completely filled	29a. Certifier (Check only one)		ysician: To the be niner: On the basis and manner	of examination										
Nithin Vithin Comp	29b. Signature and	title of certiffer	0			29c.	Licans	a number	1111		29d. Date si	gned (Month	, Day, Year)	
- > - 0	C	ator	lery	0			0	.C.M.	E.		Septemb	ber 22	, 2000	
	30. Nama and add	ess of person who	completed auto	dentili (Item :			n S	treet	, Ba	ltimor	e, Mar	yland	21201	
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Registrar		CED 9 K	2000	35 mer-a		The state of the s	da	2/1						



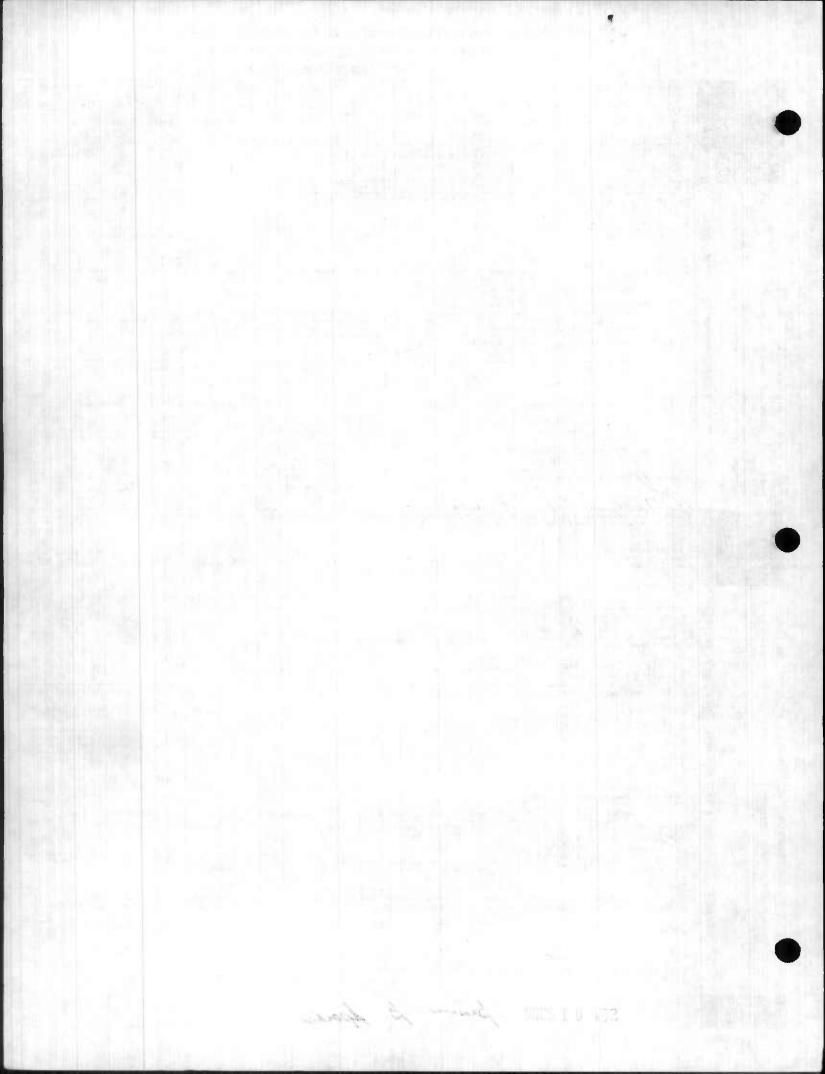
State of Maryland / Department of Health and Mental Hygiene 3 2 6 5 9

			Certificate of	Death		g. No.	02000			
	1. Decedent's Name (First, Middla, Last)				2. Dale of Death Month		3. Tima of Deal			
Physician /Medical	Iva Mae W	oods		8	EPTEMBE		2000 07:10 A			
Examiner	4a Facility Neme (If not institution, giva street and numb			4b. City, Town, or Loc		4c. County o				
4.4	St. Mary's Hospital			Leonardto	wn	St.	Mary's			
Funeral		Age (In yrs. last t	nirthday) If Under 1 Yea		B. Date of Birth (Month, Day,		Birthplace (State or For Country)			
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yland	10a. Steta 10b. County	10c. City, To	wn or Location				10d. Inside City Lin			
to the Marylan r 28a-f show rctr	Maryland St. Mary's		Colton Poi	nt			1 ☐ Yas 2 🗐			
ith the Mai or 28a-f s	10e. Street and Number		10f. Zip Code		10	g. Citizen of W	hat Country?			
th wit	37964 Enfield Lame		206	26		United	States			
fter death v	11 Marital Status 12. Was Decede	ent Ever in U,S.		Hispanic Origin? (Spec ban, Mexican, Puerto R		14. Race	- American Indian,			
8 0 5	Armed Force  1 Nevar Marriad 2 Married 1 Yes, Give  3 Widowed 4 Divorced Year or Date	№ No	1 ☐ Yes 2 ₩ No		ican, etc.)	Specify:	White, atc.			
natural, dealered by	15. Decedent's Education	16	a. Decedent's Usual Occi	pation	1	6b. Kind of Bus	iness/Industry			
ed within 72 ho ygiene. Ner then "netur nt, m. Wedeel	(Specify only highest grade completed)  Elamantary/Secondary (0-12) Collega (1-4)	05.54	(Give kind of work done life. DO NOT use retir	e during most of working ed)						
filed within Hygiene. wither than ent, ma Mer.	12		edical Aide			US Gove	rnment			
be filed of other svent, Be Cc	17. Father's Name (First, Middle, Last)			18. Mother's Name						
Mentai Mentai arked o artic sve	Frank W. McGuire			Eva Franc	es Vall	andinah	am.			
nd 2 should the lith and Ment 27 is marked to the unaffice of	19a. Informent's Name/Relationship (Type, Print)	19	b. Maiting Address (Street							
od 2 Ith a 27 is 7 fre	James A. Woods / Son		P.O. Box 10	1. Clements	Mary1	and 206	24			
semit. Pages 1 and 2 Pepartin ent of Haelih mportant: If Item 27 i nny injury or other tr 2028.	20a. Method of Disposition	20b. Place	of Disposition (Name of				City or Town, State			
permit. Pages Department of I Department: If its any injury or of DDCS.	1 ■ Burial 2 □ Cremation 3 □ Removal from Ste	916	ery, crematory or other pl		20 00 11	-1 M				
nit. Pa antmen ortant: injury	4 Donation 5 Other (Specify)	Queen	of Peace Co		29-00 H	elen, M	aryland			
Depa Impo any i	Toler Man/11	//	22. Name and Add	Bri	nsfield	Funera	1 Home, P.A.			
60260	Edward N. Brinsfield, J	r. M0005	2 22955 Hol	lywood Road	, Leona	rdtown,	MD 20650-02			
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ificate be asscuted g physician and as the burial-transit edical Examiner	Sequestially list conditions	Due to for es a	consequence of):							
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physicate as the	resulting in death) Last	200 10 101 00 0	oursequence ory.							
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that date	Cardonyopath	1 Yee 21 No 3 Probably 4 Unk								
v requires that the death cart been signed by the attendin should be datached for use.	1 100	(		fallen	24e. Wes an		24b. Were eutopsy findir			
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The law ite has boaga 2 s						<b>)</b>	of death?			
Co Co			200		1 Tes	2	1 ☐ Yes 2 No.			
clan: entific ector.	25. Was case referred to medical examiner?			26. Place of Deeth	Check only one	)				
hysic his c	1 Yas 2 Hospital: 1 Anp		outpalleni 3LI DOA	ther: 4 Nursing Hom						
ng P ther t nare	27. Menner of Death  Description 28a. Date of the (Month, (Month))	njury Day Year) 28b.	Time of 28c. Inj		ld. Describe how	v injury occurre	od			
Attending or death.  octor: After by the funalification	2 Accident investigation			Yes 2□No						
tal or Attending P as after death. In Director: After to led in by the funare Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building,	Injury - At home, etc. (Specify)	farm, street, factory, office	20	31. Location (Stre City or Town,	et and Numbe State)	r or Rural Route Number,			
Ce in Dir										
To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the Medical Certificat	29a. Cartifier (Check only 2 Medical Examiner: On the back	st of my knowledges of examination e	ge, death occurred at the ind/or investigation, in my	time, date end place, er opinion, death occurred	d due to the car d at the time, da	use(s) and man te end pleca, a	nner as stated. nd due to the cause(s)			
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al or	5. Social Security N 217-80-9	172	6. Sex 1 ☐ M 2 Ž		In yrs. last b		Under 1 Yea		n. 8. Data of 8 (Month, L August	31, 1915	9. Birthp Coun V11	laca (Stata or Fo ltry) ginia			
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Directo	Maryland	St. Ma	ary's			Chaptio	Of. Zip Code			10g. Citizen of	Man Cour	1-2			
ar, or hame 23s Examiner must. by Funeral	36175 Notley Hall Road						206			U.S.A.					
	11. Merital Status  1 Never Married 2 Married  3 🔯 Widowed 4 Divorced			Decedant Eva ed Forcas? Yas 2 X No is, Giva r or Datas:	ar in U,S.			f Hispanlc Origin? uben, Mexican, Pu lo <i>Specify</i> :	(Specify Yas or Narto Rican, etc.)	14. Red Bla Specif	ick, Whita,	marican Indian, Thita, etc. White			
eted	(Spec	15. Decedent's	s Education	ated)	16	a. Decedant's (Giva kind	s Usual Occ	cupation na during most of i ired)	vorking	16b. Kind of B	Business/Inc	dustry			
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ö	17. Fathar's Nama		ast)			110116416	-	18. Mother's N	ama (First, Middl	e, Maiden Suman					
0 8		Cager H		n				Cora	Lee Reev	res					
F	19a. Informant's N				10	b. Mailing Ad	ddress /Stre	at and Number or	Rural Routa Num	bar. City or Town	Stata Zin	Code) 2062			
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	20a. Mathod of Dis		(5011)		20b. Place	of Disposition	n (Nama of	_	Date	20c. Location					
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	21. Signature Fu				oge re	and the last of th		Genetery  drass of Facility	1 2/200	O LEON	araco	wn, Mary			
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State of Maryland / Department of Health and Mental Hygiene

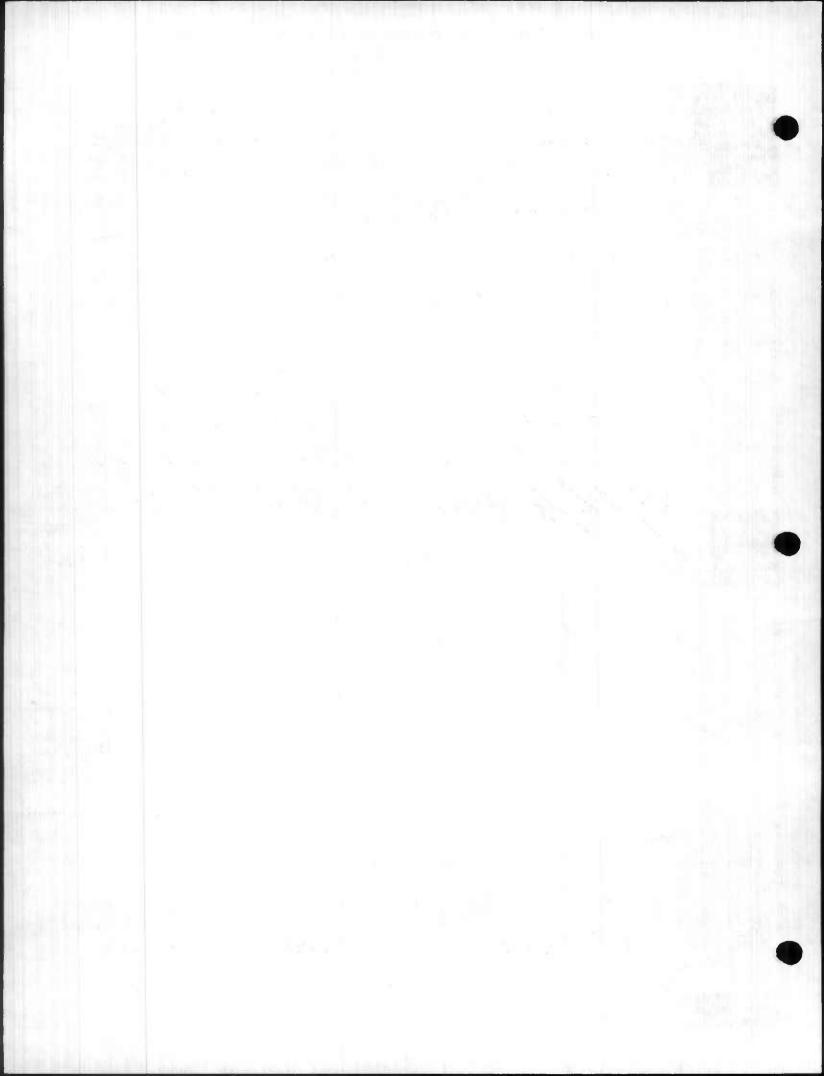
Certificate of Death 1. Decedant's Nama (First Middle Lest) 2. Date of Death **Physician** MARTHA SEPT. YEWELL 22 2000 3:12 FM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MINK HILL HOME GRASONVILLE QUEEN ANNE'S H Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) NOV. 5,1907 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2XX 218-20-4745 92 Vrs GERMANY Director Usual Rasidenca of Decedant 10a State 10b. County 10c. City, Town or Location 10d. inslda City Limits 28a-f show traumetic event, the Medical Examiner must be notified at MD QUEEN ANNE'S GRASONVILLE 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? ö 4008 MAIN ST. items 23e 21638 USA Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American indian, Black, Whita, atc. 11. Maritai Status 2 should be filed within 72 hours efter on and Mental Hygiene.
Is marked other than "natural", or its 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 ☐XNo If Yes, Give Year or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No by Specify: WHITE 3℃Widowed 4 □ Divorced Completed 15. Dacadant's Education (Spacify only highest grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working iifa. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 6 HOMEMAKER OWN HOME 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Be Peges 1 and 2 should be HEINRICK HOLDERRIETH CHRISTINA BERHARDT 19a. informant's Name/Relationship (Type, Pnint) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Code) nt of Health a : If item 27 is or other trai MARION W. YEWELL/ SON 7434 CEMETERY AVENUE, PITTSVILLE, MD 21850 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, Stata 1 X Buriai 2 Cramation 3 Ramoval from State Department o Important: If i any injury or once. CHESTERFIELD CEMETERY 9-26-2000 CENTREVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Lightner 22. Nama and Addrass of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, one cause on each line. Physician /Medical Immediata Causa (Final cancer Examiner Dua to (or as a consequence of) Examiner physician end s the burial-transit Sequantially ilst conditions, if any, laading to immediata cause. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting in death) Last Dua to (or as a consaguenca of) P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detach 1 Yes 2 No 3 Probably 4 Unknown Records, by Completed 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yas 2 ☐ No Division of Vital To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was case rafarrad to medical examinar? Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 1 Yas 2 No Medical Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28d. Describe how injury occurred 28a. Data of injury (Month, Day Year) 28c. injury at Work? 1 Natural 5 Pending Invastigation 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 Suicida 28a. Place of injury - At homa, farm, street, factory, offica building, atc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and dua to the causa(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and dua to the cause(s) and manner stated. 29a. Certifier 29b. Signatura and titla of cartifian 29c. License number 29d. Data signed (Month, Day, Yaar) 30. Name and addrass of person who completed cause of death (Itam 23a) (Typa, Print) Or we Charley, MO 2/6/9 108 A. Donuh 2000 Signature 31. Data filed (Month, Day, Yaar) State SEP

**DHMH 16 Ray 6/95** 

Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 20, 2000 Year **Physician** 11:55 AM Francis Young George /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner Lexington Park St. Mary's 22001 Valley Drive Estates Apt. 211 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) April 25, 1912 Birthplace (State or Foreign Country) **Funeral** Months Days 1MM 2□ F Hours 220-16-7880 88 Maryland Director Usual Residence of Deceden the Maryland 10e State 10c. City, Town or Location 10d. fnside City Limits 10b. Count 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director Maryland Lexington Park St. Mary's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 6 U.S.A. 20653 22001 Valley Drive Estates Apt. 211 items 23s filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 12. Was Decedent Ever In U,S. Armed Forcea? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Tes 2 No If Yes, Give Year or Dates: 1□ Yes 2No Specify: Maryland 21215-0020 ò Specify: Black Completed by 3 Widowed 4 Divorced \*natural', 16a. Decedent'a Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) 5th College (1-4or 5+) Farm Farmer permit. Peges 1 and 2 should be file Department of Health and Mental Hy, Important: if fam 27 is marked othe any injury or other traumatic event, bace. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Philip Young Mary Neil 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20653 19a. Informant's Name/Relationship (Type, Print) Catherine Young (Spouse) 22001 Valley Drive Estates Apt. 211 Jexington Park, MD Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 Burlal 2 Cremation 3 Removal from State 9/25/00 Our Lady's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Leonardtown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 uchast Hardiner 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ronaro Examiner Physician/Medical Examiner 10mc Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last use es the burial-tran The law requires that the death certificate be execu Box 68760. pertensive Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by 1 Yes 2 No 3 Probably 4 Unknown Also and Attendors.

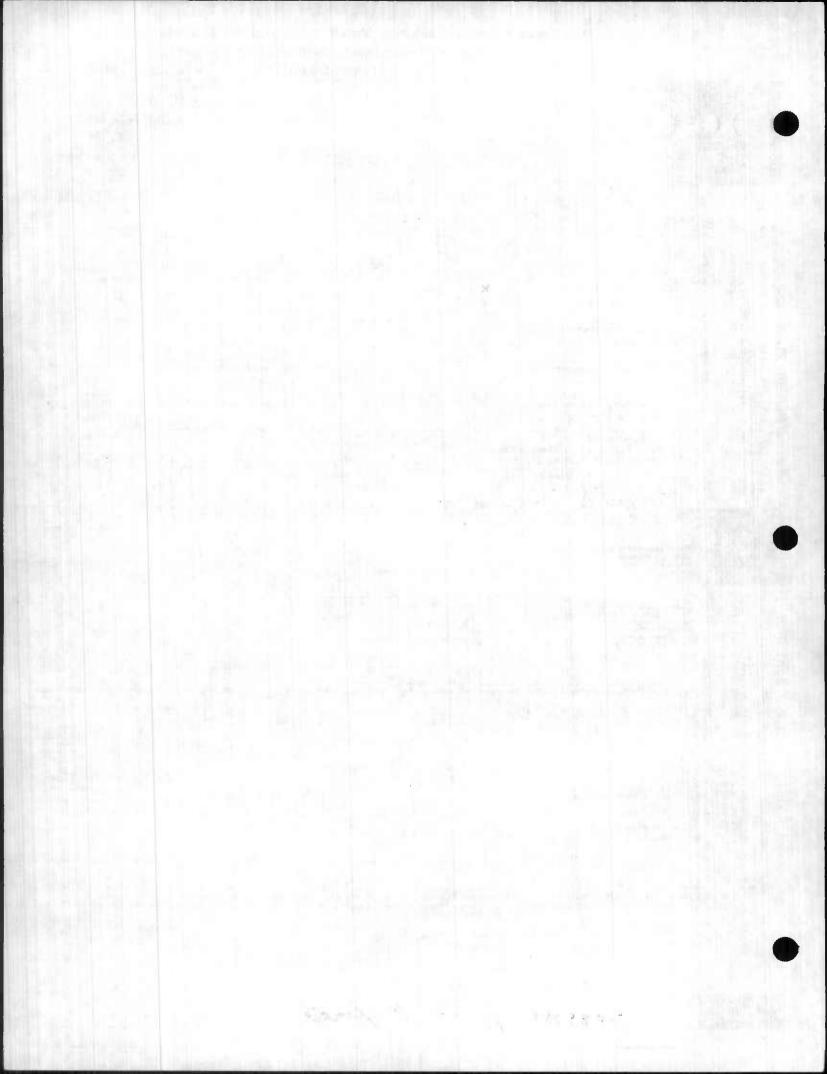
Just after death.

erel Director: After this cartificate hes been suggested by the funeral director, page 2 should be defended in by the funeral director. Division of Vital Records, 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? completion of cause of death? astroesupho n J 1 Yes 1 ☐ Yes 2 ☐ No concerg ancex 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of 27. Manner of Death 28c. injury at Work? 28d. Describe how Injury occurred 1 Wetural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital within 24 hours a To the Funerei D 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, and due to the ceuse(s) and menner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kae T. Aung, MD Hollywood, Maryland 20636 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

Registrar

SEP 2 5 2000



1 - FOR STATE REGISTRAR

### STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

REGISTRAR		CER	TIFIC	ATE O	F DEATH	F	IEG. NO.		
1. DECEOENT'S NAME (First, Middle, Last)	G					2. DATE OF MONTH	DEATN DAY	YEA	3. TIME OF DEATH
Louis Edwir						Sept.		2000	5:00 P.M.
4. SOCIAL SECURITY NUMBER 214-36-9035	5. SEX 6. A	GE (In yrs. last bir		UNDER 1 YEA		7. DATE OF 1 (Month, De July	28. 19	- C	RTHPLACE (State or Foreign country)
9a. FACILITY NAME (If not institution, give :	street and number)		96	CITY, TOW	N OR LOCATION OF D			c. COUNTY C	
210 Hiob Lane RESIDENCE OF DECEDENT 100. STATE 100. COUNT MD H				Ab	erdeen			Harfo	
10a. STATE 10b. COUNT	Y	-10	De. CITY, TO	OWN OR LO	CATION				10d. INSIDE CITY
MD H	arford			rdeen					LIMITS?
10e. STREET AND NUMBER					10f. ZIP CODE		10	g. CITIZEN (	OF WHAT COUNTRY?
210 Hiob Lane					21001			U.S	.A.
10. STREET AND NUMBER  210 Hiob Lane  11. MARITAL STATUS  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. WAS DECEDENT EVI FORCES? 1 Q V IF YES, GIVE WAR O 1959-196	ER IN U.S. ARMED PES 2 NO PROATES		If yes,	ECENDENT OF NISPA specify Cuban, Mexic ES 2 XNO Speci	an, Puerto Rica		S	ACE — American Indien, Black, Whita, atc. pecify: White
15. DECEDENT'S EDU (Specify only highest grade	CATION	18a. DECED	ENT'S USL	JAL OCCUP	TION	16b. KIR	ID OF BUSINE		
15. DECEDENT'S EDU (Specify only highest grade 12 12 12 17. FATNER'S NAME (First, Middle, Last)	College (1-4 or 5 +)	life. Do	NOT use re	noloy	most of working	1	Veldin	C.	
17. FATNER'S NAME (First, Middle, Last)				np101	18. MOTNER'S N.			_	
Louis Frederick	Zupancic					Bell I		raine)	
19a. INFORMANT'S NAME (Type/Print)		19b. M	AILING ADI	DRESS (Street	et and Number or Rural		_	tate, Zip Code	)
Beverly E. Zupa	ncic (Wife)			ob La		rdeen,			21001
20e. METNOD OF DISPOSITION 1	oval from State	20b. PLACE AND cemetery, cremato P.O.S.	DATE OF D	ISPOSITION place	(Name of	OATE	20c. LOCAT	ION — City o	r Town, State
21. SIGNATURE OF FUNERAL SERVICE LI		P.U.S. (	OL A.	22. NAME	AND AGORESS OF F	CILITY			le, PA
* Kermeth k	3 Con	· _		Tar	ring-Cargo rdeen, Ma	o Funer	al Ho	me, P.	.A.
IMMEDIATE CAUSE (Final disease or condition resulting in death)	DUE TO (OR	lighte AS A CONSEQUE	CO'	were	y arte	u d	year	e	Ovjett
Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR A	AS A CONSEQUE	NCE OF):						n A
Sequentially list conditiona, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Diseese or injury that initiated events resulting in death) LAST	DUE TO (OR A	AS A CONSEQUE	NCE OF):						
	a contributing to deal	h but not resu	iting in ti	a underly	Ing cause given in	Bort I 04	. WAS AN AUT	manay I	
				- Unidarry	ing cause given in	- 1	PERFORME	07	24b. WERE AUTOPSY FINDINGS AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH	YES	□ NO	UNCERTAI	N 🗆			1 TYES 2 NO
DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATN	HOSPITAL:	26. PLACE OF	01	HER:					
27. MANNER OF CEATN	1 Inpatient 2 ER/	-	b. TIME OF		ome 5-1 Realdence				
1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Ye		INJURY		NJURY AT WORK?  YES 2 NO	286. OESCRII	BE NOW INJU	RY OCCURE	
3 Suicide 6 Could not be 4 Nomicide determined	28e. PLACE OF INJ building, etc. (	URY — At home, Specify)	term, stree	t, tactory, of	fica	281. LOCATIO City or To	N (Street and i wn, State)	Number or Ru	ral Route Number,
	CIAN: To the best of my k								se(a) and menner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIES					29c. LIGENSE NU				IED (Month, Day, Year)
17 luc V	O COMPLETED CAUSE OF	DEATH (ITEM 27	(Type Prin	()	0 70	//		4/2	9100
CHICLES EUC:	ralmo 2	19W.B	EL	ACC	ALE 1	13E-020	EFE	2,40	> 24001
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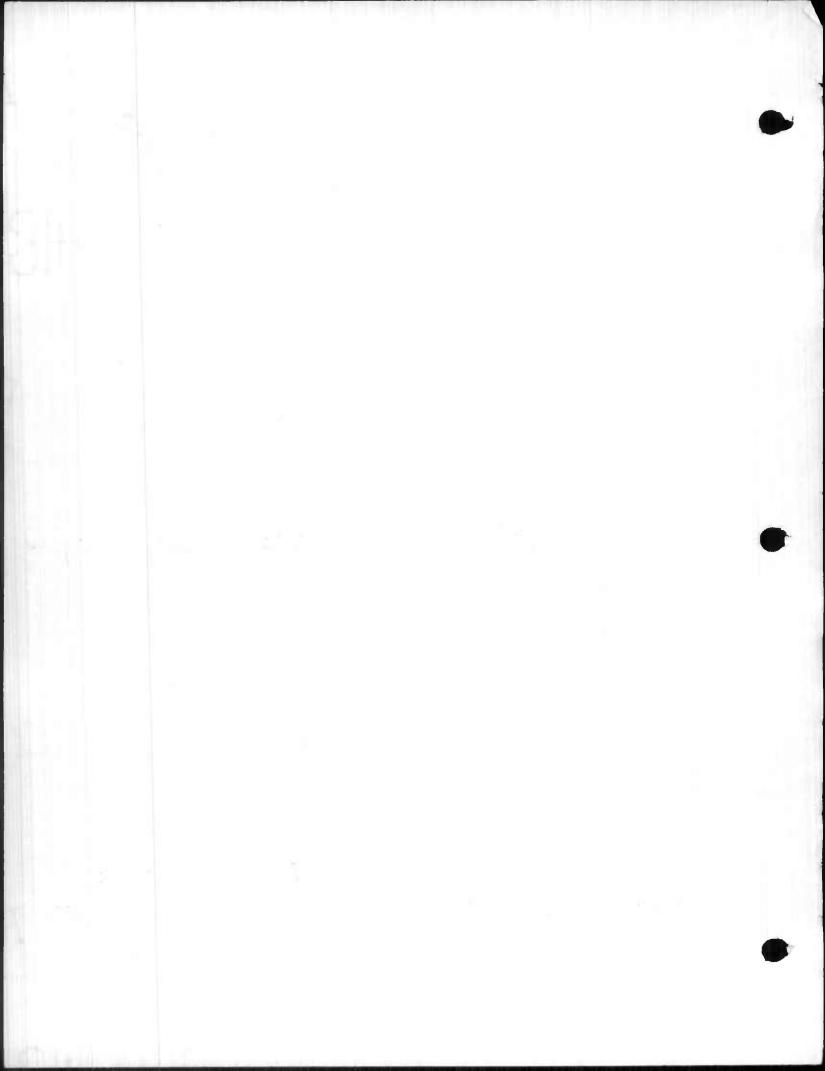
3041

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

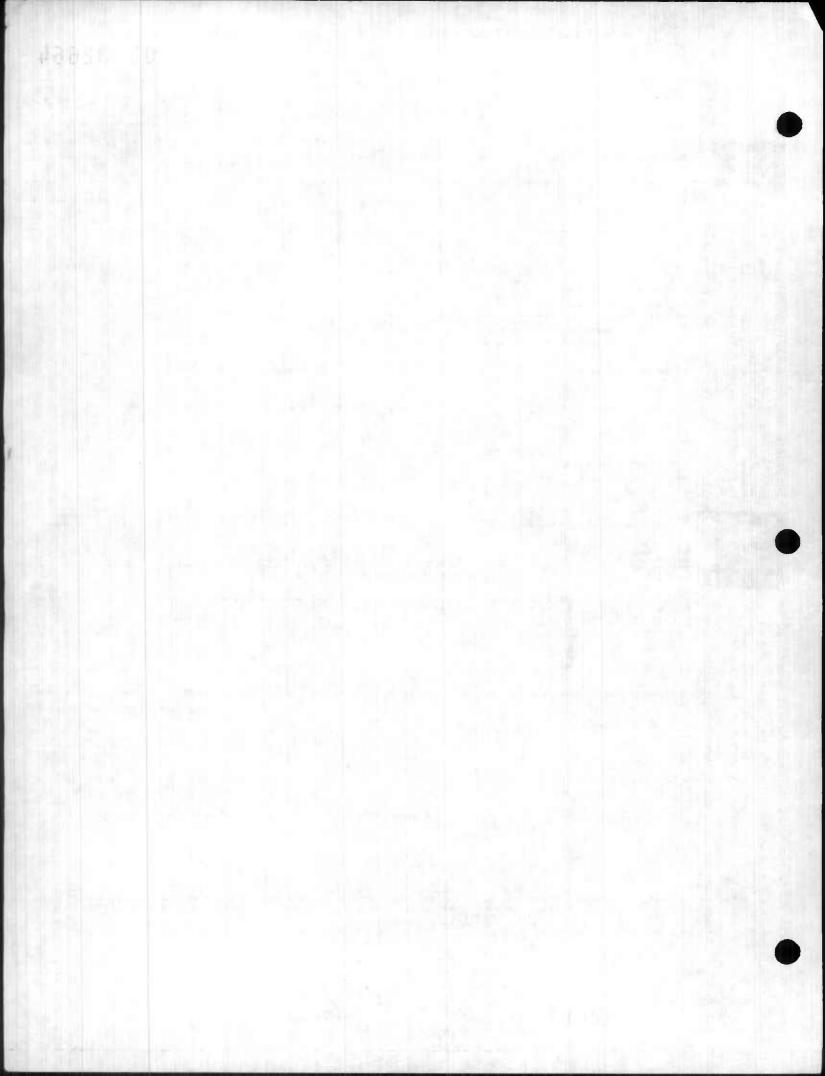
DIVISION OF VITAL RECORDS, P.O. BOX 68760



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 11 32664

					Certific	ate of	Death		Reg. No.		02004
Physic	ian	1. Decedent's Nama (First, Middla, Le	ast) A	Her	2			2. Data of De Month	Day ,	Year	3. Time of Death  12:13 Am
/Med	ical	4a Facility Nama (If not institution, gin		1161	1		4b. City. Town.	or Location of Deatl		O Deeth	16.17
Exam	ner	2505 Painter	Court				ANNE	APOLIS	ANA	UEX	ARUNDEC
Funera Director		216-44-3645		(In yrs. last bir	Yrs. If Ur Mont	hs Days			<sup>b</sup> . 1912	9. Birthp Coun	placa (Steta or Foreign ntry)
pu R.		Usuat Rasidanca of Decedent  10a. Stata 10b. County	1	10c. City, Tow	n or Location					1	I Od. Insida City Limits
se Maryl Ba-f sho diffied a	Director	Maryland Anne A	rundel				polis				1 ☐ Yes 2 No
ith with the Maryli 23e or 28e-f sho ust.be notified at	ral Dire	10e. Streef and Number 2505 Painter Co	urt	20	10f.	Zip Coda 214	01		10g. Citizen of V		itry?
0020 ours after des	by Fune	11. Marital Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas:			specify Cub specify No		(Specify Yas or No arto Rican, atc.)	Blac	e - Amaric ck, Whita, V: Whi	
5-0 72 hg	eted	15. Decedant's E (Specify only highast gr		16a.	Decedent's U	Jsuat Occu work dona	pation during most of v	vorking	16b. Kind of Bu	usiness/In	dustry
21215-0020 of within 72 hours at giens, or then "netural", or the Medical Exam.	Comple	Elementary/Secondery (0-12)	College (14or 5+)	) A	`#a <i>DO NO</i> nalyst		od)		Federal	L Gov	rernment
Maryland Service to the tiled of the marked other treumstic event.	To Be C	17. Fathar's Nama (First, Middle, Last Clement C. Lidd					18. Mother's Mary I	Nama (First, Middla Kiburz	Maidan Suman	na)	
M M M M M M M M M M M M M M M M M M M	F	19a. Informant's Name/Ralationship	(Type, Print)	19b	. Maiting Add	ress (Stree	and Number or	Rural Route Numb	er, City or Town,	Stata, Zip	Coda)
Mand 2		Norval Allen/husb	and	2	505 Pa	inter	Court	Annapoli	s, MD 21	1401	
Pages 1: tent of Ha nut: If Nam rry or oth		20a. Mathod of Disposition  1 □ Burial 2 ◯ Cramation 3 □  4 □ Donation 5 □ Other (Speci			Disposition ( ny, cramatory  Crema			Data 10/16/00	20c. Location -	-	own, Stata .more, MD
Baltii permit. I Departm Importar any inju		21. Signature of Funaral Service Lice	<u> </u>		22. Name Cre	a and Addr Matio	n Societ	ty of Mar	yland,	Inc.	
		Dawn F. McDona  23a. Part 1. Entar tha disaasa, or conshock, or haart failura. List only		na death. Do	299	Fred mode of dy	erick Ro	oad Balt diac or respiratory a	imore, M	1D 21	228 Approximata Interval Batween Onset and Death
Physician /Medical Examiner		Immediata Causa (Final disaasa or condition rasulting in death)	a. META				T CA	NCER			34RS.
	ē		D	ue to (or es e	consequanca	of):				i	
8760, sate be assecuted whysician and the burial-trensit	Examiner	Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disaasa or injury	b	ua to (or as a	consaquanca	of):					
68760, rifficate be assecutificate be assecutificate be assecuted es the burial-tree	edicai	Cause (Disaasa or injury that initiated evants resulting in death) Last	C	ua to (or as a	consaquanca	of):					
			d								
	icia	Part II. Other significant conditions	confributing to death buf	not rasulting i	n fha undarivi	na causa a	van in Part I.	23b. Did	tobacco uss co	ntributs t	to the cause of death?
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= F 5 a	Comp							10	Yas 20 No	1[	☐ Yas 2☐ No
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M = E 00 TI	. To	1 Yas 2 No 27. Menner of Death	1 L Inpatiant		utpatient 3	DOA	4 LI Nursin	g Homa 5. Ras	danca 8 Oth		fy)
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Div To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical		hysician: To the best of miner: On the basis of a and manner state	xamination an							
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V		30. Nama and addrass of rson who	complated cause of dea		(Type, Print)	6101	11865	Ave do	2B AN	NAS	POLIS MD
Si	ate	31. Data filed (Month, Day, Year)	32. Registrar	Signatura	, 5	1	212 10				21401

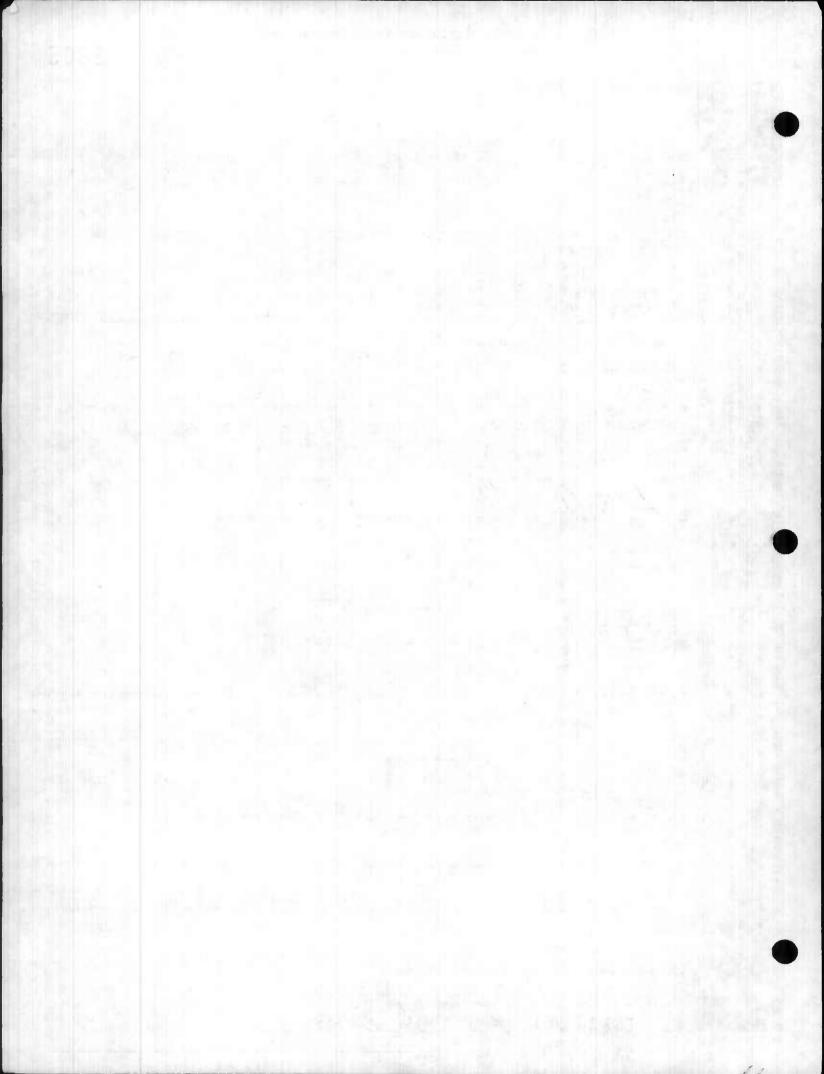


#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 32665

						Certificate of	Death	Re	g. No.	
	14114		1. Decadent's Name (First, Middla,	Last)				2. Data of Death Month		3. Tima of Death
0	Physicia /Medic	~ ~	ROBERT	LE	E	ABRAMS		OCTOBER	12, 2000	5:25 AM
	Examin	_	4a Facility Nama (If not institution,	giva street and number)			4b. City, Town, or Lo	ocation of Death	4c. County of Dea	ath
1			BRIGHTWOOD MER				LUTHERVII		BALTIMOR	
ľ	Funeral Director		217-48-5581	5. Sex 7. Ag 1 X M 2 □ F	a (In yrs. last bi	rthday) if Under 1 Yea Yrs. Months Days		8. Deta of Birth (Month, Day, SEP 22	,1950 9. Bi	rthplace (Stata or Foraign Country) MD
	and and	1	Usual Rasidence of Dacedant  10a. Stata 10b. County		10c. City, Tov	m or Location				10d. Insida City Limits
	e Mary le-f sho tifled a	ctor	MD N/A		BALTI	MORE				1X Yas 2 No
	uth with the Marylar 23a or 28a-f show ust be notified at	al Director	10e. Street and Number 3200 FALLSTAE	F ROAD		10f. Zip Code	21215	10	U.S.A.	Country?
020	hours after dea ural", or items at Examiner ma	by Funeral	11. Marital Status  1 Never Merried 2 Merrie 3 Widowad 4 Divorced	12. Was Decadant Armed Forces?  1 📉 Yes 2 🗆 If Yas, Giva Year or Datas:		13. Was Dacedent of if Yas, specify Cul		ecify Yas or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0020	nin 72 h	Completed	15. Decedant' (Specify only highast Elemantary/Secondary (0-12)	Education grada complatad) Collega (1-4or 5		Decedant's Usual Occu (Giva kind of work done lifa. DO NOT usa retir	upation a during most of work ed)	ing	6b. Kind of Businas	s/Industry
	d will glene ar the	E O	Cioniantaly/Secondary (0-12)	2		MINISTRATOR		44-11	TOMSON-PE	ROMETRIC
Maryland	S of the	Be (	17. Fathar's Nama (First, Middla, L				18. Mothar's Nam	a (First, Middle, N	faiden Sumama)	
yla	Marks Marks	2	MELVIN	J.		RAMS	LUCILLE			COLDSTEIN
Mai	d2 sh h and h se m treum		19a. Intormant's Name/Ralationsh SANFORD ABRAMS			b. Mailing Addrass (Street				
é,	Healt mm 2 other	-	20a. Mathod of Disposition	/ BROTHER	20b. Place 0	corswold Corsposition (Nama of ory, crematory or other pl			Oc. Location - City of	
timore	A DE LE		1 ☐ Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other (Sp			GTON CHIZUK	1	10/16/00	BALTIMOR	OE MD
Balti	Departm mporter eny inju		21. Signatura of Funaral Sarvice L		7	22. Nama and Addi				BROS., INC.
		-	220 Phat Enter the disease of	- www	W dooth Do	1	TERSTOWN I			
	Physician /Medical Examiner		23a. Pārt1. Enfer the diseese, or o shock, or haart failura. List o Immediata Causa (Final diseasa or condition resulting in death)	1.	way	bladder	Curcino			Approximata Interval Between Onset and Death
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68760,	ificete be executed g physician and as the burial-fransit	edical Examiner	Sequentially list conditions, if any, laading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted evants	0	Dua to (or as a	consequance of):				
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amended Item#16a,b,19a,b perFHG788 10 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#7 perFHG788 10/17/2000 EW Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** BOLDEN 124/AN OCT 55 PH 2000 /Medical 4a Facility Name (If not institution, give street and number) 2 H APEL HILL 4b. City, Town, or Location of Death 4c. County of Death Examiner MD RANDALLSTOW J TO NSG. CTR MMOR LOBOSSON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplaca (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Day, Year) 10 M 70 F **Funeral** Days Months Hours 18-36-828 82 Yrs. Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Baltimore Randallstown 1 ☐ Yas 2 No MD Director event, the Medical Examiner must be notifi-10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? b 21133 USA 4511 Robosson Road Name 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marifel Stetus 72 hours after 1 ☐ Never Married 2 ☐ Merried 8 21215-0020 1 ☐ Yes 2 ☒ No Specify: black þ 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

unlc Collega (1-4or 5+) Hygiene. filed within Elamantary/Secondary (0-12) Balto City School System Teacher Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) h and Mental is marked of ed bluods George Lottier Lilian Armstrong 19a. Informant's Name/Relationship (Type, Print) - Unit 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) \_\_\_\_\_\_\_\_\_ Pages 1 and 2 if of Health If Nam 27 i 9451 Fitzharding Lane Owings Mills ,Md Patrice Williams - Daughter Baltimore, 20b. Placa of Disposition (Name of cametery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation—5 ☐ Other (Specify) ö Department if two or any injury or once. 21. Signature of Euneral Service Sicensee, Director 23 Name and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201 Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** Immediate Cause (Final diseasa or condition rasulting in death) /Medical Phulmenia Examiner Due to (or as a consequence of) Physician/Medical Examiner hachic Demuntic use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Dua to (or as a consequence of): Box 68760. the attending physician Due to (or es e consequenca of) P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Vesculer 12-5 - Ch5 4 Division of Vital Records, P 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed ual or Attending.

Jis after death.

Frail Director: After this certificate has be filled in by the luneral director, page 2 strained in by the luneral director. 1□ Yes 2☑No 1 Yes 2 No Certification: To Be 25. Was case rafarred to medical 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding Investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicida filled In To the Hospital within 24 hours a To the Funeral I completely filled Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one)

State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month Day Year) 7 2000

J.

29b. Signature and title of certifier

Chincus M.0 32. Registrar's Signature Densey

0.0

chur

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

028085

29d. Date signed (Month, Dav. Year)

21133

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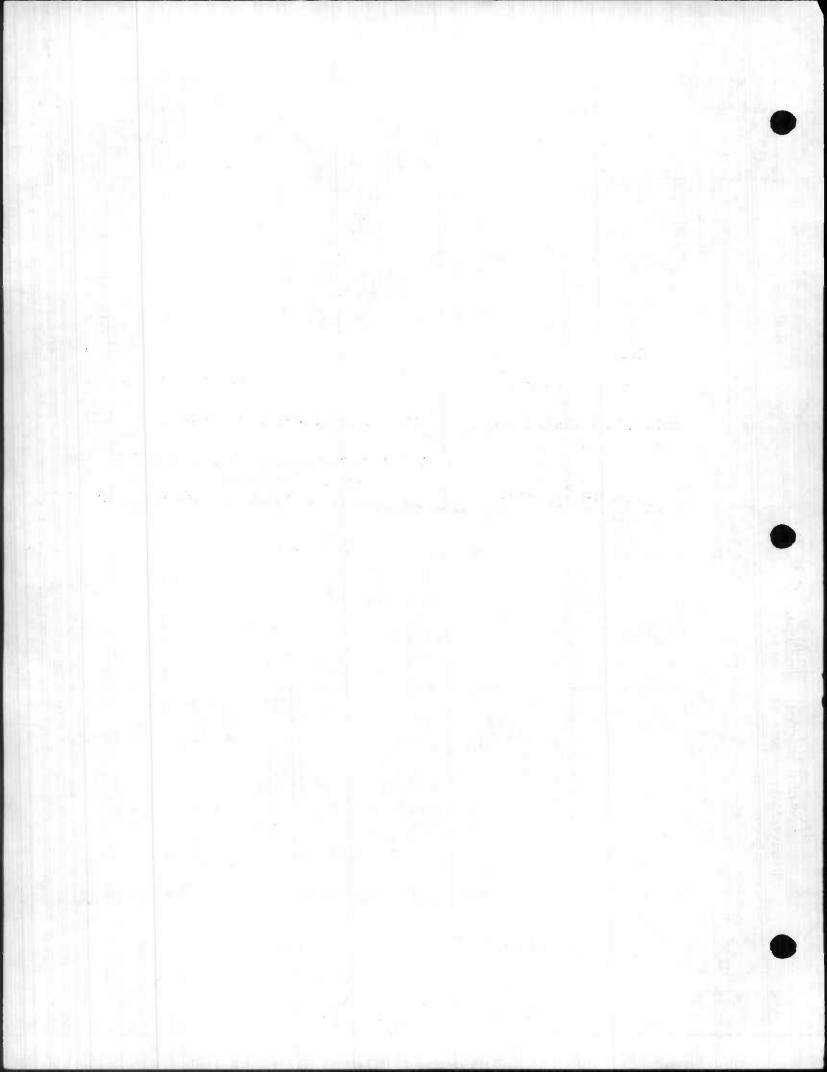
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State of Maryland / Department of Health and Mental Hygiene 0 0 3 2 6 6 7

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	neral ector	5. Social Security 217–13–8	631		7. Age (In yrs.	last birth			If Under 24 Hrs.		Year)		olace (Stata or Foraign http) MD
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he Hospital in 24 hours.	otely fill	29a. Certifier (Check only one)	10 Certifying Ph 2 Medical Exam	nysician: To the t niner: On the ba- and mann	sis of axamina	owledge, stion and/	death occurred for investigation	at the ti	ima, data and place opinion, death occu	, and due to the c rred at tha time, d	ause(s) and ma lata and place,	annar as s and dua to	tated. o tha cause(s)
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Re	State egistrar	31. Data filed (Mor	OCT 17	2000 D	gistrar's Signa		6.	An.	2. 16 1				



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Tima of Death **Physician** BIRK Month (NMN) **EDMUND** OCTOBER 13, 2000 12:20 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner SEVERNA PARK ANNE ARUNDEL GENESIS ELDER CARE If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Days Hours NOM 2□F 87 Yes Director 212-10-5951 WI JUNE 25.1913 Usual Rasidence of Decedent with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director ANNE ARUNDEL GLEN BURNIE 28a-f MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number mast be 7302 GREEN ACRES DRIVE 21060 U.S.A. Funeral or itsems 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status Bleck, White, etc. Pages 1 and 2 should be filled within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: WHITE Specify. py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION CARPENTER 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Surname) ant of Health and Mental H.
rut. If them 27 is married y or oth Be ALEXANDER BIRK MARY HALLIKAS 2 19e. Informent'a Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 7311 MARLEY NECK BLVD., GLEN BURNIE, MD. 21060 MRS. DAWN HANSON (DAUGHTER) 20b. Place of Disposition (Nama of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition W Burial 2 ☐ Cremetion 3 ☐ Removal from State GLEN BURNIE, MD. 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN MEMORIAL PARK 21. Signeture of Funerel Septem License 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 100 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 has thet caused the death. Do not entar tha mode of dying, such as cardiac or respiretory arrest, cause on each line. Approximata Intervel Between Onset and Death Physician Immediata Causa (Final disease or condition resulting in death) /Medical lear Examiner Physician/Medical Examiner or Attending Physician: The law requires that the deeth certificate be executed the burial-tren Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last P.O. Box 68760, Due to (or as a consequence of): ate has been signed by the attending p page 2 should be detached for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4€ Unknown Division of Vital Records, Be Completed by 24b. Wera eutopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 2/200 ascu 1 Yes certificate director. 25. Wes case refarred to medical examiner? 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of After 1 Matural 5 Pending investigation 1 Yes 2 □ No death. 2 Accident ofter death \$ 28l. Location (Street end Number or Rural Route Number, City or Town, Stete) To the Hospital or Attention 24 hours efter del Leute Funeral Director competely filled in by the 3 ☐ Suicide 6 Could not be detarmined 28e. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, data and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred et the time, date end place, end dua to the ceuse(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signatura and title of ce

State Registrar ohn

31. Dete filed (Month, Day, Year)

DHMH 16 Rev 6/95

304 Severa Park, MD

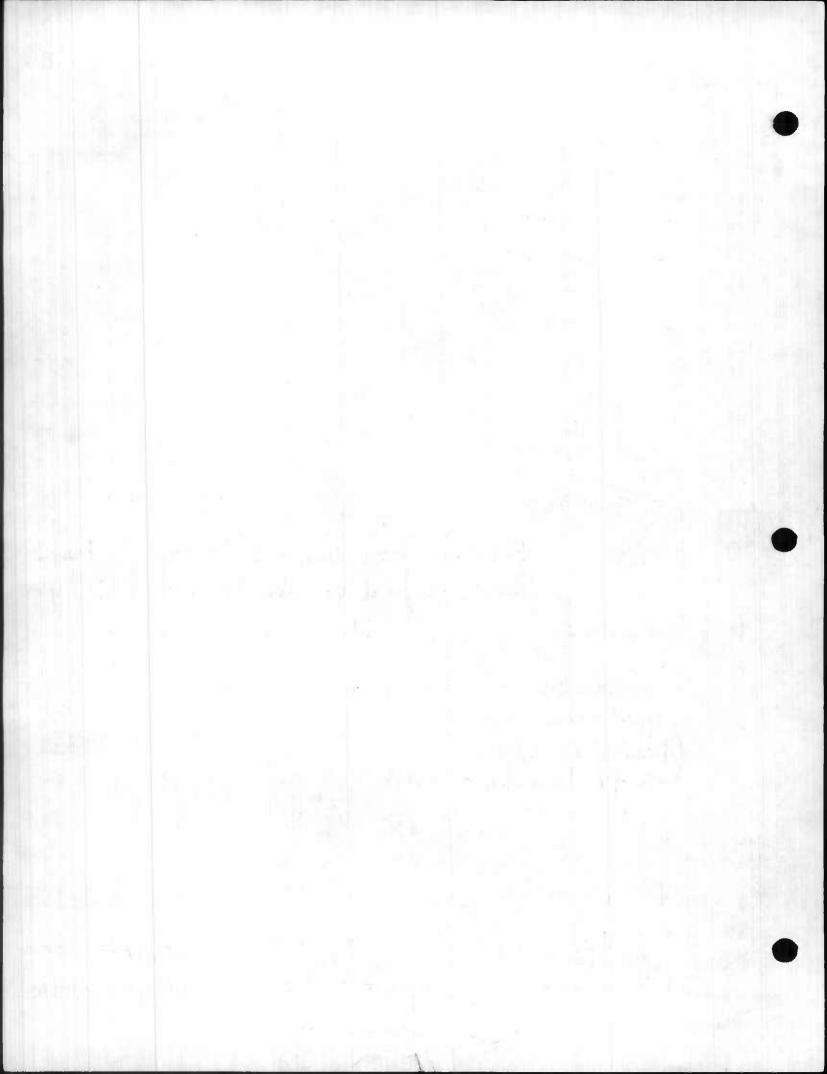
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32. Registrar Signeture

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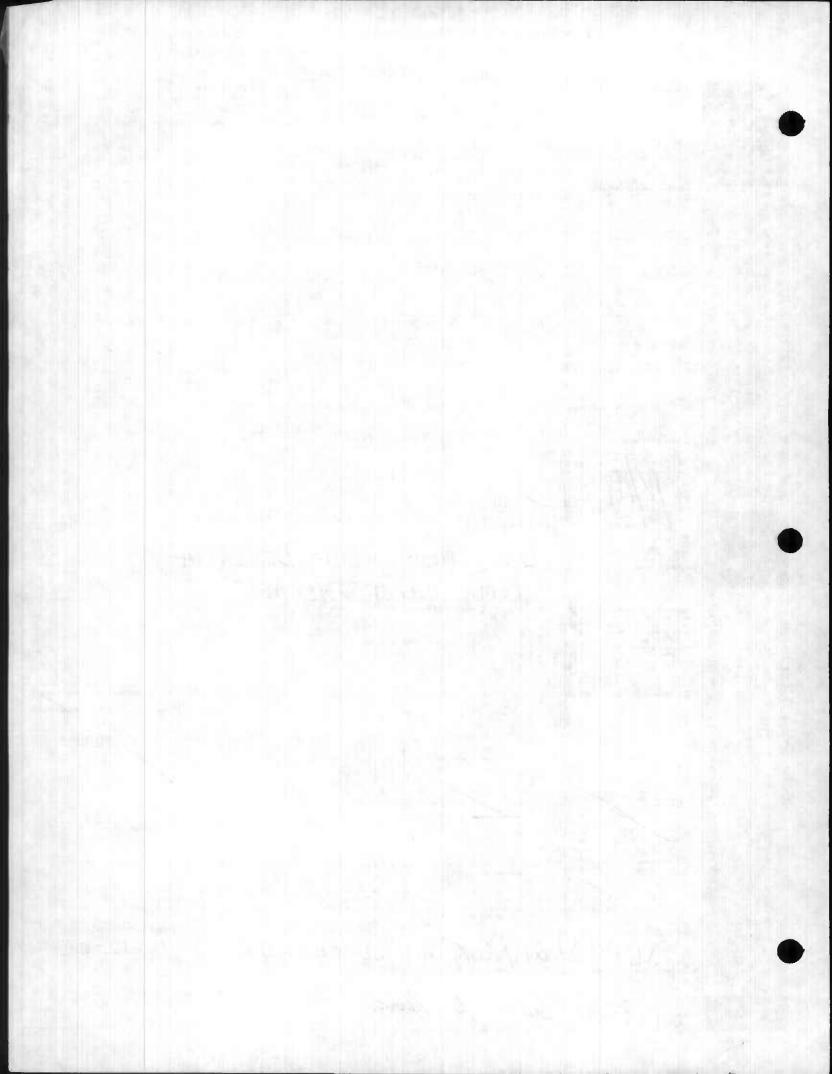
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State of Maryland / Department of Health and Mental Hygiene 00 32669

		AMEND#26 PER MD. G788	10-17-2000 JAB	Ce	ertificate of	Death		Reg. No.	
		1. Decedent's Name (First, Middla, La			avu da ra	-1167-1-1	2. Data of De Month	ath Day Yaar	3. Tima of Death
	Physician /Medical	CHESTER	FRANK		BORUTA		OCTOBE		2:20 AM
	Examiner	4a Facility Nama (If not institution, git	ra street and number)			4b. City, Town, or I	Location of Deatl	4c. County of Dec	ath
		STELLA MARIS NURS	SING HOME			TIMONITI	TM	BALTI	MODE
	Funeral	5. Social Security Number 6.	Sax 7. Aga (In yrs.	last birthday	/) If Under 1 Yea Months Days		8. Date of Bir (Month, Da	th 9 Bi	rthplaca (State or Foreign
	Director	376-26-9995	1 M 2□ F 85	Yrs.	Months Days	Hours Min.			HIGAN
	9	Usual Residence of Decedent							II CORN
	how how	10a. Stata 10b. County	10c. Ci	ty, Town or I	_ocation				10d. Inside City Limits
	cto cto	MARYLAND ANNE AF	RUNDEL	AN	NAPOLIS				1 ☐ Yes 2√∏No
	vith the Mar or 28a-f al be northed	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	death with the Maryland rms 23e or 28e4 show rmust be northed at	835 COACHWAY			2140	01		US	A -
		11. Marital Status	12. Was Decedent Ever in U Armed Forcas?	J,S. 13	. Was Decedent of	Hispanic Origin? (S ban, Maxican, Puart	pecify Yes or No	14. Raca - Am Black, Wh	
0	F.			945-	1 ☐ Yes 2 ☑ No		0 1 110411, 4(0.)		110, 510.
00	o P			965	I THE SERVICE	эреспу.		Specify:	WHITE
5-0	ed within 72 hours after ygiena. For then "natural", or he the western Enterthal to the Completed by Fu	15. Decedent's E		16a. Dec	edent's Usual Occu	upation e during most of wor	rkina	16b. Kind of Busines	s/Industry
21215-0020	-	Elementery/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retir	ed)	nnig		
	Hygiena. Ther ther ent, the		4	MILI	TARY LING	GUIST		SOCIAL SE	CURITY
pu	be filed within tal Hygiena. d other then event, me the	17. Father's Name (First, Middle, Last	)			18. Mother's Nar	ne (First, Middle,	, Maiden Sumame)	
Maryland	should be filed within and Mental Hygiena. Imarked other than umatic event, the MTO Be Comp	FRANK		BORU	TA	ANNA			BOLEK
a	ges 1 and 2 should t of Health and Mer If Item 27 1s marks or other traumatic	19a. Informant's Name/Reletionship	Type, Print)	19b. Ma	ling Address (Street	et and Number or Ru	iral Route Numb	er, City or Town, Stete,	Zip Code)
	1 and 2 Health em 27 I	MS MADELINE AGLU	BAT (DAUGHTER	) 1010	CHESTNU	T RIDGE D	RIVE. LI	THERVILLE	MD 21093
ore	of Herry	20a. Method of Disposition	20b. i	Plece of Disp	position (Neme of ematory or other pl	ace)	Date	20c. Location - City o	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tronce.	1 Burlal 2 Cremation 3 C	JHamovai from Stata		EN MEMOR		10/13/20		TE MD
=======================================	pemit. Pag Department Important: I any Injury c	21. Signature of Furniral Service Lice					NGLETON	GLEN BURN FUNERAL HO	
ä	Degree	DIVALA I	111.00					LN BURNIE,	
		23a. Part Enter the disease, or com	plications that caused the dea	th. Do not a					Approximata
N.	ALCOHOLD .	spock, of heart failure. List only	one ceuse on each line.	50 1101 0		my, soon as said	or roophatory a		Interval Between Onset and Death
	Physician /Medical	Immediate Cause (Final	C C:D		0_	. 7.			
18	Examiner	disaase or condition resulting in death)	. END STI	1616	SENI	E DE	MENT	IA	
п	- in		Due to (	or as e cons	equenca of):				
	nin min		. PEPTIC	UL	CER L	)ISEH2	SE	because in the	
	the death certificate be assected by the attending physician and ached for use as the burial-transit hysician/Medical Examiner	Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (	or as a cons	equence of):				
68760,	be a bound bunia	cause. Enter Underlying Cause (Disease or injury	C						
87	attending physician for use as the burial Clan/Medical E	resulting in death) Last	Due to (d	or as a conse	equanca of):				
×	ding I		d.						
Вох	ttenc or us								
0	that the death ce ed by the attend datached for us;	Part II. Other significant conditions of	contributing to death but not res	ulting in the	underlying cause g	iven in Part I.	23b. Dld	tobacco use contribu	te to the cause of death?
<u>.</u>							10	Yea 2 No 3	Probably 4 D Onknown
Ś	8 6 8 Q				- TOO IN				
ord	The law require sate has been significantly page 2 should Completed						24a. Was	an autopsy 24b	. Were autopsy findings available prior to
00	has be								completion of cause of death?
ď	The la			/			10	Yas 20 No	1 Yes 2 No
Vital Records,	certificate rector, pag	25. Was case referred to midical				26. Place of Dea	ath (Check only	one)	
>	Physician: this certific ral director. : To Be	examiner?	Hospital:	ER/Outpati	ent 3 DOA	thor		denca 6 □Other (Sp	ecify)
of	Physical properties	27. Manner of Death	28a. Dete of Injury	28b. Time				how injury occurred	
0	tal or Attending P rs after death. In Director: After the ed in by the funers Certification:	1 Netural 5 Pending 2 Accident Investigatio	(Month, Day Year)	Injury		Yes 2 No			
Division	death. ctor: A by the fu	3 ☐ Suicide 6 ☐ Could not b	Zoe. Place of injury - At I	ome, fam, s	street, factory, office	9	28f. Location (	Street end Number or I	Rural Route Number,
Ö	or Attend after death Director: d in by the	4 Homicide	building, etc. (Speci	fy)			City or To	wn, Stete)	
EI)	ours ours	29a, Certifier 1 Certifying Pt	ysician: To the best of my kno	wiedge, des	th occurred at the	time, date end plece	and due to the	ceuse(s) and manner	as stated.
	To the Heepital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification	(Check only 2 Medical Example)	niner: On the basis of examina and manner stated.	ition and/or	nvestigetion, in my	opinion, deeth occu	irred et the time,	date end place, end de	ue to the ceuse(s)
	N Sabie	29b. Signature and titla of cartifier	1_	10 11 1	29c. Licer	nse number		29d. Date signed (Mor	nth, Day, Year)
	PATEN	Xamax	nandar	han	Da	2/18/1/	11		2-00
	4	MIMO	myw,	IVID	100	4000	10	70-1	2 00
	010	30. Neme and eddress of person who							
-	- V	DR. RAMA SHANKAR,		_	RIVER NE	CK ROAD,	BALTIMO	RE, MARYLAN	ID 21221
	State	31. Data filed (Month, Day, Year)  OCT 1 7 2000	Servis Signi	Atura Ago	ocks				
	Registrar	OCT 1 7 2000					1637		



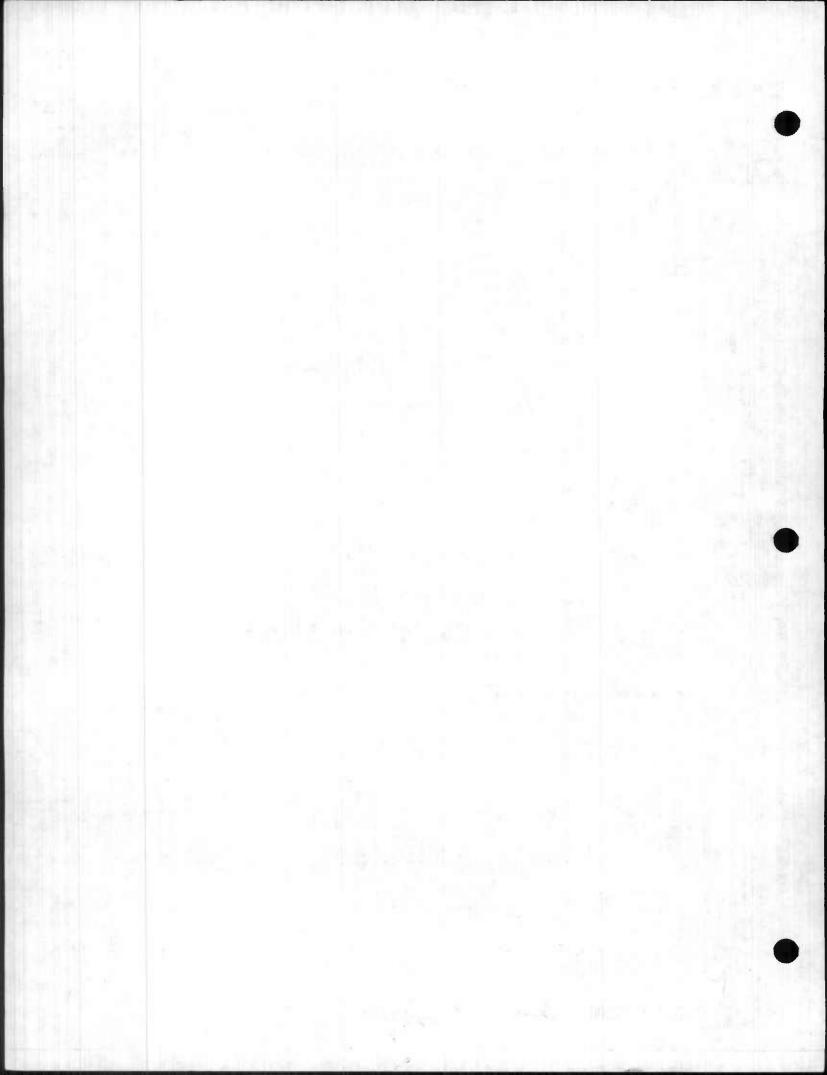
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Sea No. 32670

Physician /Medical Examiner	1. Decedent's Nar				Cei	niiicai	e or	Death		Reg. No	),	
/Medical		ne (First, Middle, L	ast)						2. Dete of i	Death De	v Ye	3. Time of Death
	Charlott 4a Facility Name			m <i>ber)</i>				4b. City, Town	OCTO:	per 1	-	00:00
	Union Me	morial H	ospital				Ва	altimor	e			
Funeral Director	5. Social Security 213-34-2	Number 6. 749	Sex 1□M 2∏F	7. Age (In yrs. 76	last birthday) Yrs.	If Under Months	1 Year Deys	If Under 24	Hrs. 8 Date of I	Dey, Year)	1924	Birthplace (State or Foreig Country) Germany
ž.,,	Usuel Residence of	10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
or or	MD	D-1-4-		Cata								1 Yes 2 No
or 28a-f a	MD 10e. Street and No	Baltime	ore	Cate	nsvill	10f. Zig	Code			10g. Ci	tizen ot Whet	21
23a or		twood Ro	ad			212	28			USA		
ral', or items 23a or 28a-f ahow Examine must be notified at 1 by Funeral Director	3 ₩ Widowed	rled 2 Married	Armed Fo	2⊠ No ve				lispanic Origin en, Mexican, P Specify:	? (Specify Yes or Puerto Rican, etc.)	No-		American Indian, White, etc. hite
marked other train "natural, made event, the Made event To Be Completed by	(Spe	15. Decedent's cify only highest goodery (0-12)	Education irede completed) College (			kind of wo DO NOT u	ork done se retired	pation during most of d)	working		(ind ot Busine	
O S	12		2		Bookk	ceepe:	r	40.11.11	No. of Contract Address		counti	ng
item 27 is marked other than other traumatic event, the M To Be Comp	17. Father's Neme		st)						Neme (First, Midd	ne, Maider	i Sumame)	
To the	Julias F							Marie				
T 5		leme/Relationship							or Rurel Route Nur			
item 27 other tu		Edward B	orisevic							_		yland 21158
important: If item 27 any injury or other tr once.		sposition Cremetion 3 5 Other (Spec		State	Place of Disponentery, cres			ce) 1 Garde	October ens 17,200	in		or Town, State ile, Marylan
de by the attending physician and detached for usa as the burial-transit auripposition of Physician/Medical Examiner	shock, or he Immediate Cause disease or conditive resulting in death Sequentially list or if any, leading to incause. Enter Und Cause (Disease of that Initiated even resulting in death) Part II. Other sign	onditions, mmediete ertying r Injury ts	e	Due to (c	or es e consecutivo de la consecutivo della cons	quenca ot)  QUI  quence ot)  Quenca ot):	eau	tation to Factor	ilire	ld tobacco	o use contrib	Interval Between Onset and Death  2 hours  1 day  1 day
Phy th									1	□ Yee :	2 No 3	Probably 4 Unkno
cartificate has been signed lirector, page 2 should be de- o Be Completed by P					5,8				pe pe	as an auto		4b. Were eutopsy tindings available prior to completion of cause of deeth?
icate	00.111										No	1 ☐ Yes 2 12 No
s cartific director, To Be	25. Was case rete examiner?		Hospital:	/			Ott	hor:	Death (Check on			
1 - F	1 Yes 2 2	No	28a. Dete		ER/Outpatie		JA	4 LI Nurs	ing Home 5 ☐ Re		6 UOther (	Specify)
al Director: After thised in by the funeral Certification: 1	1 Naturel 2 Accident 3 Suicide	5 Pending investigati	(Mon	oth, Dey Year) of Injury - At h	Injury	М		rk?`  Yes 2∐No				or Rurel Route Number,
the Funeral Director: inperially filled in by the Aedical Certifical	4  Homicide	determine		ing, etc. (Speci		ieet, iactor	y, omce		City or	Town, Stei	te)	
- T	29a. Certifier (Check only one)	1 Certifying F	eminer: On the b	best of my kno easis of examine ener steted.	owledge, deat etion end/or in	th occurred evestigation	et the tin	me, date and popinion, deeth	oleca, and due to to occurred at the time	he cause(s ne, date an	s) and manne nd place, and	er as stated. due to the cause(s)
odio adio	20h Signatura an	d title of certifier				29	c. Licens	se number				Aonth, Dey, Year)
Medical	230. Oignotore on						1.00	2120	1	0-1		17 7 00
Medic	250. Signistare on	the	-				כיוו	2107	4	CCT	2,000	12 man
on the Funeral Director: A companies will like the funeral Director: A companies of filled in by the funeral Director: A companies of filled f	1	Iress ot person wh	o completed caus	se of deeth (Item	m 23e) (Type,	, Print)	Citt	POIC	y has	UC+	ober	13 2000 Hazzita



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middle, Last) 2. Data of Deeth 3. Tima of Death Month Carolyn LaVern Booker 1:10Am October 15,2000 4a. Fecility Nama (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Baltimore Care If Undar 24 Hrs. 8. Data of Birth Hours Min. 7. Month, Day, Charlestown Cente 5. Social Security Number If Under 1 Year 7. Aga (In yrs. last birthday) Birthplace (Steta or Foreign Country) 18. Data of Birth (Month, Day, Year) January 14, 1916 Pennsylvania 1 M 2 F Days Months 170-12-9736 84 Yrs Usual Rasidanca of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Baltimore Catonsville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 709 Maiden Choice Lane 21228 USA 12. Was Decedant Evar In U,S. Armad Forces? 1 ☐ Yas 2 Å No If Yes, Giva Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Bleck, Whita, atc. 11. Marital Status 1 Navar Married 2 Married 1 ☐ Yas 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decadant's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Homemaker OwnHome 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maldan Surname) Andrew Clark Jenny Barton 19a. Informent's Name/Retetionship (Type, PrInt) 19b. Meiling Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) Rick Jay- Son 3821 Bonnybridge Place, Ellicott City, Maryland 21043 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata October 1 Burial 2 Cramation 3 Removal from Stata Crestlawn Memorial Gardens 18, 2000 Marriotts ville, Maryland 22 Name and Address of Facility 4 Donation 5 □ Othar (Specify) 22. Nama and Address of Facility Witzke Funeral Home, Inc. 21. Signatura of Funaral Service Licansee 1630 Edmondson Avenue, Catonsville, Maryland 21228 23a. Part 1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. Listoply one ceuse on each line. Approximata Intervat Batween Onsat and Death Immediata Causa (Final 2 weeks disaasa or condition rasulting In daeth) Dua to (or as a consequanca of): Sequantially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Diseesa or injury that Initiated avants rasulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings evellebla prior to completion of cause of death? 24a. Wes en autopsy performed? 2 DING 1 Yas 1 ☐ Yes 2 ☐ No 25. Was case ratarrad to medical 28. Plece of Deeth (Check only ona)

**Physician** /Medical **Examiner** or Attending Physician: The law requires that the death certificate be executed

Box 68760,

P.O. I

Division of Vital Records,

**Physician** 

/Medicai

Examiner

10a. State

Director

Funeral

by

Completed

12

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If frem 27 is marked other than "natural".

ending physician or use as the burial Physician/Medical signed by the þ Completed After this certificate has Be P Certification: after death. by the

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Othar: 4 1 Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify) 1 Yas 2 10 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Daath 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? 1 DNatural

5 Pending invastigation 1 Tyes 2 No 2 Accidant 3 Sulcida 6 Could not be 28e. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata)

4 Homicida 29a. Certifian

1 Certifying Physician: To the bast of my knowledga, daath occurred et tha time, dete and placa, and due to tha causa(s) end mannar as stated.

2 Medical Examiner: On the basts of exemination and/or invastigation, in my opinion, daath occurred at the time, dete end placa, end due to the causa(s) and mannar stated. (Check only one) 29b. Signetura and title of cartifian 29c. Licansa number 29d. Data signed (Month, Day, Year)

30. Nema end address of person who complated causa of death (Itam 23a) (Type, Print)

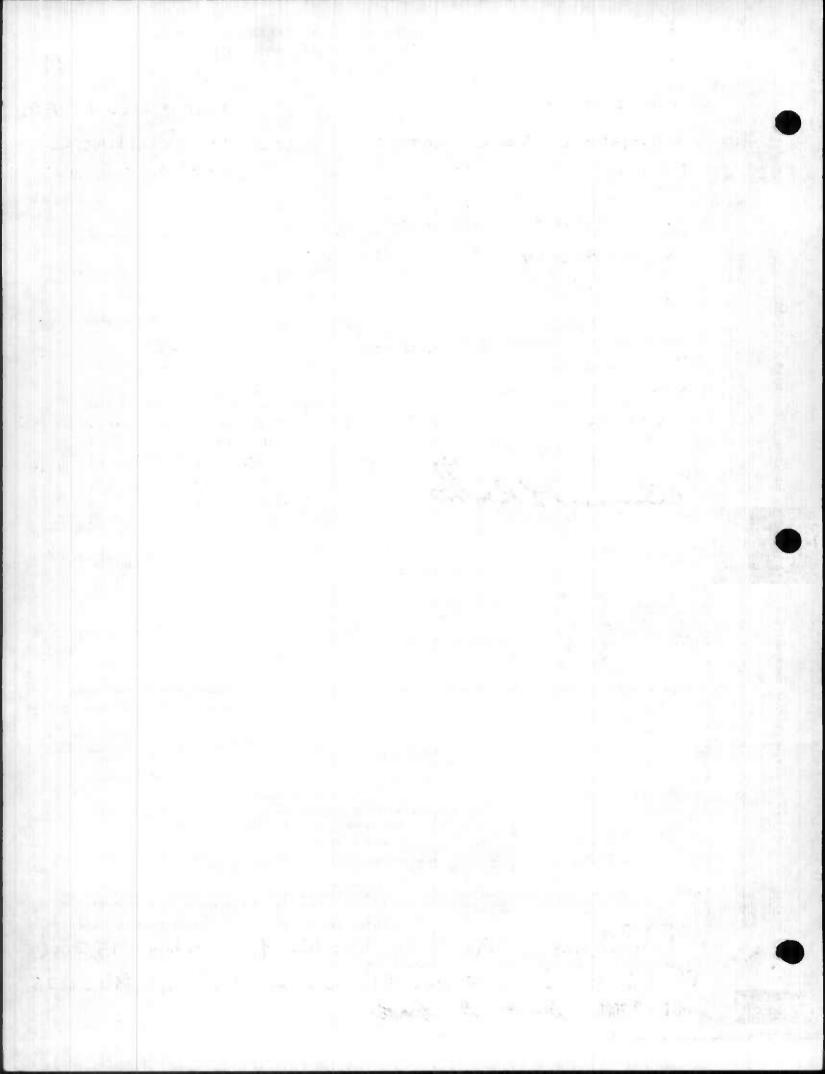
Phillip Sto 31. Dete filed (Month, Day, Year) OCT 1 7 2000 Maiden Choice Lane, Baltimore, MD 21228 tone 32. Registrar's Signatura

Registrar

Medicai

DHMH 16 Rev 6/95

Within 24 hours a To the Funeral C



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32672 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 11:15Pm Gladys M. Burkins BER 2.000 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) GLEN BURNON If Under 24 Hrs. 8. Date of Birth (Month, Day, (In yrs. last birthday) Months Days Hours Virginia 1 M 2 XX 89 Yrs. 2/16/1911 198-05-4224 Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 528 Oakwood Station Road 21061 USA 12. Was Decedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Yas YA No If Yes, Give Year or Datas: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 XX Specify: white **3**CWidowed 4 □ Divorced 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grada completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Johnson Hodge Margaret A. Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Norman E. Burkins - Son 528 Oakwood Station Road, Glen Buirnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 10/13 Glen Haven Cemetery Glen Burnie, MD 22. Name and Address of Facility FINK FUNERAL HOME, PA 21. Signatur of Funeral Service Ligense Kelly Gregory Fink 426 Crain Hwy., SW, Glen Burnie, MD 21061 23a. Part1 Enter the distance or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart turbes. Lat only one cause on each line. Approximate Interval Between Onsat and Death Immediate Cause (Final disease or condition resulting in death) BREAST CANCER mo Sequentially list conditions, if any, laading to immediate ceuse. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Minknown 24b. Wera autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 ☐ Yes 2000 2 NO 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2000 1 Impatient 2 ER/Outpatient 3 DOA 28c. Injury at Work?

**Physician** /Medical Examiner be executed

frem 27

Pages

SHOOLS

**Physician** 

/Medical

Examiner

Directo

Funeral

þ

Completed

Be

**Funeral** 

Director

Physician/Medical Examine The law requires that the death certificate þ Be Completed Medical Certification: To

Box 68760. P.0. Records, of Vital or Attanding Physician: Division after death. Director: Af within 24 hours a Hospital

> State Registrar

completely

To the

DHMH 16 Rev 6/95

27. Manner of Death Natural

5 Pending investigation 2 Accident 3 ☐ Suicide 4 Homicide

29b. Signature and title of certifie

29a. Certifier

6 Could not be detarmined

28b. Time of Injury

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

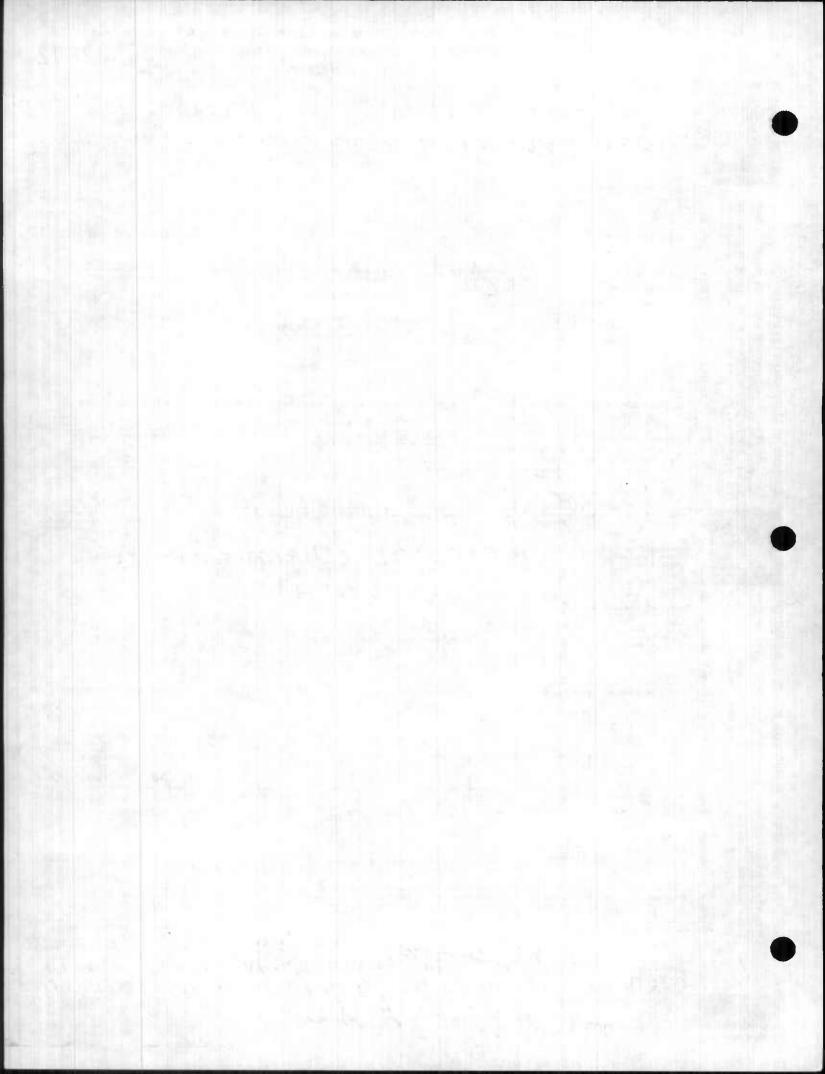
2 Medical Examiner: On the bests of examination and/or Investigation, In my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29c. Licansa number D 5 1 66 4

29d. Date signed (Month, Day, Year)
OCTO BER 10 2000

STOHIR KUMBR TGA RMAL, 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) HOSPI TAL 31. Data filed (Month, Day, Year)

32. Registrar's Signature

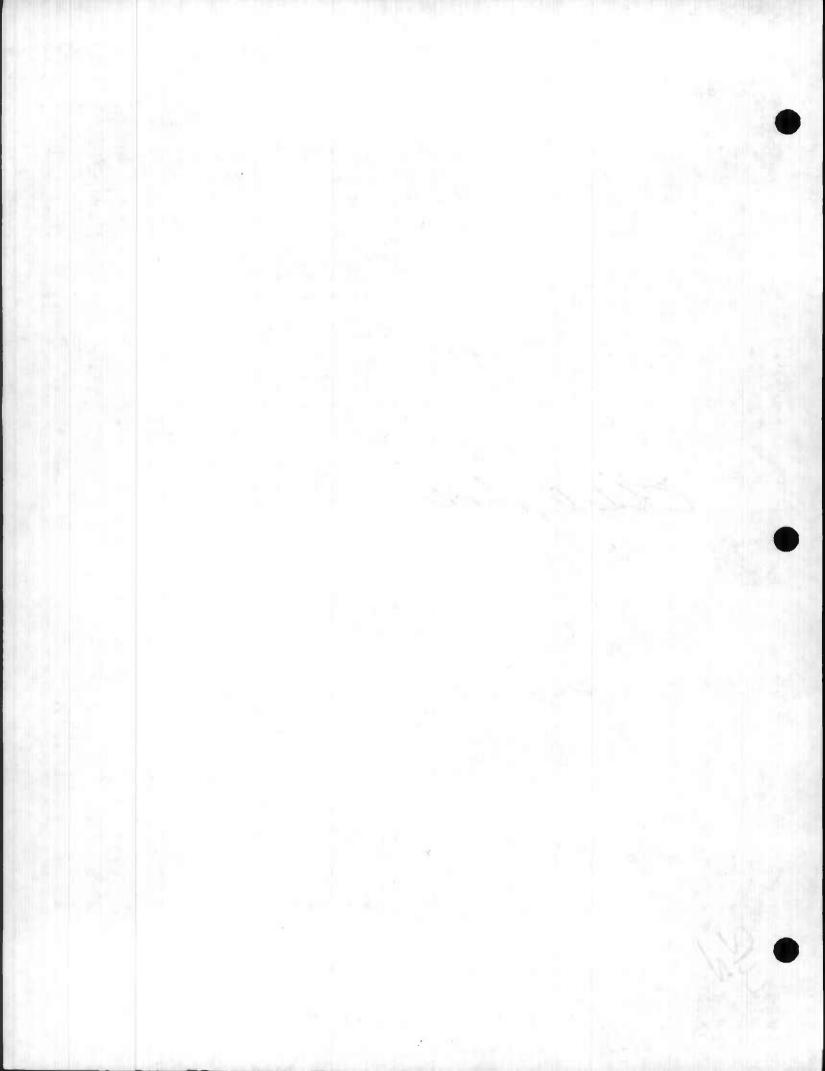


#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	1. Decedent's Neme (First, Mido	de l'esti			061	rtificate of	Death		2. Dete of De	Reg. No.			3. Time of Death
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al .		BANKS	at and no	mharl			4h City To	-	OCTOBE cation of Deet		200 County of		10:15 AM
er	4e Facility Neme (If not institution	7. 7.		im <i>ber)</i>						100			DODLO
	6120 LIVINGSTO  5. Social Security Number	6. Sex	ND	7 Age (In vi	s. lest birthdey)	If Under 1 Yee		N HI		1	-	-	ORGE'S
1	111-38-5551		2 F	r. Age (m)	5.2 Yrs.	Months Deys		Min.	8. Date of Bir (Month, De AUG 11				ece (Stete or Foreig Iny)
	Usuel Residence of Decedent				32		لد سيال		AUG_II	1940	IN.	EW 3	LOKK
	10a, Stete 10b. County	у	151	10c. (	City, Town or Lo	ocation						10	d. Inside City Limit
	MARYLAND PRIN	ICE GE	ORGE	119	OXON	HTT.T.							1 ☐ Yes 2 💢 🎉
Ì	10e. Street and Number	.02_02				10f. Zip Code		MILL TO		10g. Citize	en of Whe	at Count	Iry?
	2115 ALICE AVE	ENUE	APT	203		2	0749			U.S	. A.		
	11. Merital Stetus	12,1		edent Ever in	U,S. 13.	Was Decedent of it Yes, specify Cui		gin? (Spec	cify Yes or No		4. Paca -	America White, e	
	1 Never Merried 2 Me	rried		2 No		1 ☐ Yes 2 ☐ (No			tioari, oto.,			ville, e	sic.
	3 ☐ Widowed 4 🖾 Mivorce	d	Yeer or E	Detes: 68/	77	10 102 5/1/10	, орвену.		0.00	°	Specify:	BLAC	CK
	15. Deceder (Specify only higher	nt's Education		)	(Give	dent's Usual Occu	during mos	t of working	ng	16b. Kind	d ot Busin	ness/Ind	ustry
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ŀ	12th grade				CABL	E TECHIC					SPOR		ION
	17. Father's Neme (First, Middle	, Last)							(First, Middle		umeme)		
ŀ	JOSHUA BANKS								AE SWI				
1	19e. Interment's Name/Reletion	ship (Type,	Print)			ng Address (Stree							
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DHMH 16 Rev 6/95

Registrar



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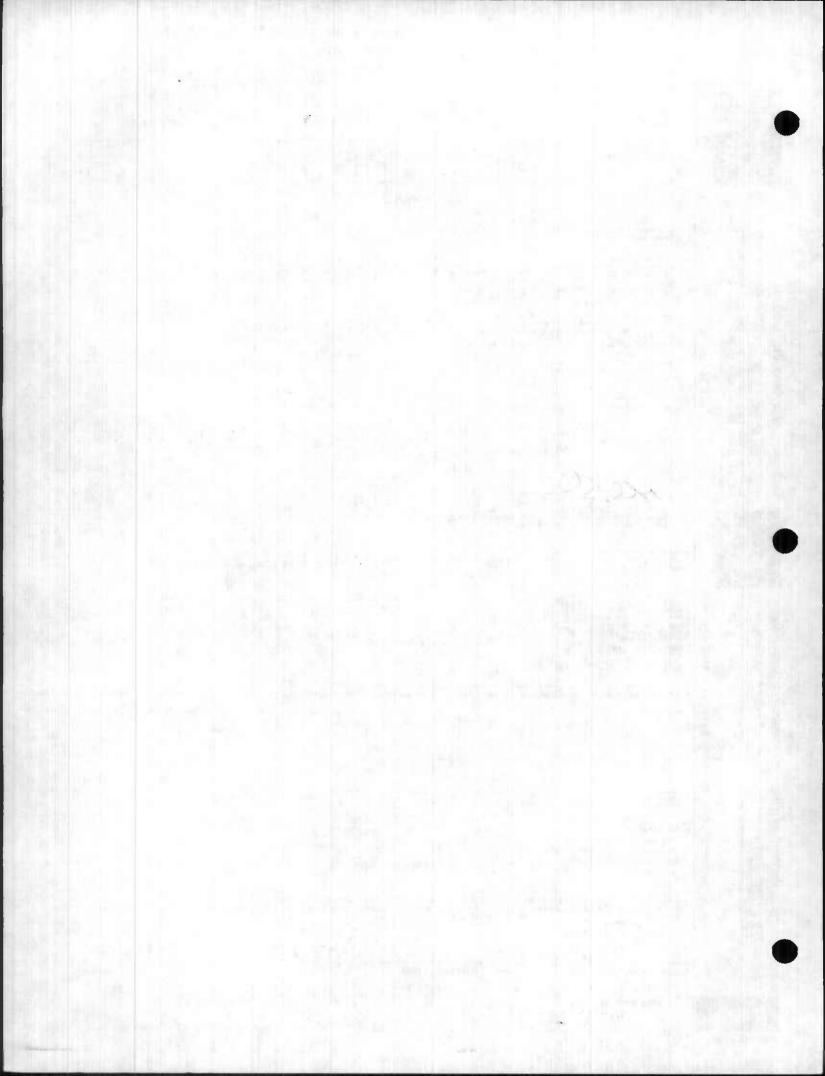
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**DHMH 16 Rev 6/95** 

October 13, 2000 6:20 a.m.

Baltimore, Maryland 21215-0020

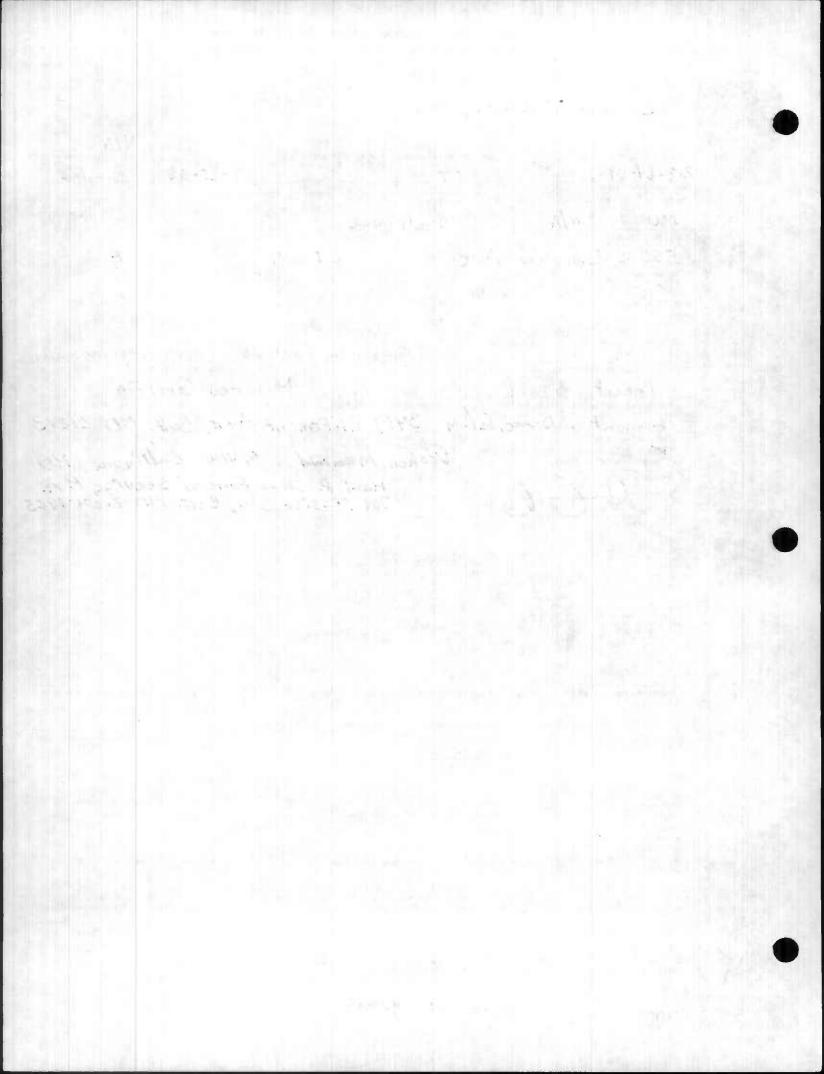
Division of Vital Records, P.O. Box 68760, Alice Elizabeth Bigham



### Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32675

т	AMONITE DE	ARD amend item 23a,ptII,27,28a,b,c,d,e,f permission of Death			32013
بيا	AMONT BE	1. Decedent's Name (First, Middle, Last)	2. Dete of De		3. Time of Death
	Physician /Medica	- mariat / Dearn In	Month OCT.	Day 14, 2000	Year 1256 PM
	/Medica Examine	4a Facility Name (If not institution, give street end number)  4b. City, Town, o	r Location of Death		
UV.		JOHNS HOPKINS HOSPITAL BALTIM			N/A
	Funeral Director	5. Social Security Number  2/8-64-0984  6. Sex 1  7. Aga (In yrs. last birthday) 4  4  4  7rs.  Usual Residence of Decedent			9. Birthplace (State or Foreign Country) Many land
	hend fend	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	death with the Maryland ms 23s or 28s-f show f.must be notified.	MO N/A Baltimone			1 → Yes 2 □ No
	ifer death with the Ma r items 23e or 28e-f s niver mult be notified	10e. Street and Number 10f. Zip Code	4	10g. Citizen of W	hat Country?
	23a	5503 Lynview Ave 21217		U.	SA
		11. Mantal Status  12. Was Decedent Evar in U,S. Armed Forces?  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No orto Ricen, etc.)	- 14. Race Black	- American Indian, c, White, etc.
20	ours after death with the Manyler ral", or thems 23s or 28s-4 show Essempler must be notified at	1 Nevar Merried 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced Yaar or Datas:		Specify:	Black
Ö	filed within 72 hours after Hygiene. Ther than "natural", or its out, the Medical Examina	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Bus	
215	led within 72 ho lygiene. her than "naturi nt, the Medical	(Specify only highest grade completed) (Give kind of work done during most of wife. DO NOT use retired)  Elementary/Secondery (0-12) College (1-4or 5+)	^	. 1	
2	Hygiene. Hygiene. ther ther mt, the	Security Gua	wd	House	
	2 5 5 5	17. Fathers Name (First, Middle, Last)	10 red		
7	d 2 should be th end Mentel 7 is marked of traumatic ever	19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I			
	2000		AVE		MD 21213
w w	Of T of	20a. Method of Disposition 20b. Place of Disposition (Neme of	Date	20c. Location - 0	City or Town, State
	Pag nent: H	1 Formation 3 Ramoval from State 4 Donation 5 Other (Specify)	10/21/200	Balt	mone, MD
Salt	permit. Page Department o Important: If i eny injury or once.	21. Signeture of Funeral Service Legisee 22. Name and Address of Facility	e tuner	al sen	VICE P. A.
m 	80558	709 Tessier	5 to. Ba	It. MO	21201-1925
		23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cerdishock, or heart feilure. List only one cause on each line.	ac or respiretory a	rrest,	Approximate Intervel Between Onset and Death
ا(ر	Physician /Medical	Immediate Ceuse (Final			Orisot and Doams
	Examiner	diseese or condition resulting in death)  MIXED DRUG INTOXICATION			1
		Due to (or as a consequence of):			
	lew requires that the death certificate be executed as been signed by the attending physician and a should be detached for use es the burial-transit	Sequentially list conditions, if any, leading to immediate	F 118		
60,	clan clan burial	cause. Enter Underlying Cause (Disease or Injury			
68760,	physicate s the	that initiated events resulting In death) Lest  Due to (or as e consequence of):			
Box	attending for use e	d			
Ď	death death death	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did	tobacco use con	tribute to the cause of death?
P.0	v requires that the death cert been signed by the attending should be detached for use		10	Yee 2 No	3 ☐ Probably 4 ☑ Unknown
Ś.	es this		-		0.00 100
010	The lew requir			en autopsy omad?	24b. Were autopsy findings available prior to completion of ceuse
Rec	has b				of death?
	ysician: The I s certificate ha director, page		1,23		1 Ø Yes 2 □ No
5	Physician: r this certific rel director.		Home 5 Resi		or (Specify)
0	5 5 6			how injury occurre	
Sior	Attending F r death. sctor: After by the funer	1 □ Neturel 5 _ dending four Manth, Day Year) unknown M 1 □ Yas 2 \(\infty\) Year) 10/14/00			
Σ	tal or Attending P	3 ☐ Suicide 6 MXCould not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or To	wn, Stelle) Cont	er or Rurel Route Number, tral Booking,
	hours a meral D by filled			City, Md.	nnar es elejad
	To the Hospital within 24 hours for the Funeral completely filled	(Check only one)  27 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death ocone)  and manner stated.			
	within 24 h To the Fur completely			29d. Data signed	(Month, Dey, Year)
	(1)	Stuck & Wlacks M.A O.C.M.E		OCT. 1	5, 2000
	ille	30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)			
	0 1	Stephen S. Radentz, 111 Penn Street, Baltin	nore, Mar	yland 21	.201
	State Registra	31. Deta filed (Month, Dey, Year)  OCT 1 7 2000  32. Registrer's Signatus			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 11844PM Mabel B. Baker ctober /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Franklin Square Haspital Kosedale Canter Baltmore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months 1 M 28 F 212-09-6829 April 20, 1919 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MXYes 2 No Director N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 320 S. Bouldin Street 21224 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Never Married 2 ☑ Married ☐ Yes 2ENo f Yes, Give 1 Yes 2 No Specify. Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) 1 and 2 should be Health and Mental George M. Backert Sr. Mabel Battee 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) James Baker 320 S. Bouldin Street Baltimore, Maryland 21224 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burlai 2 ☐ Cremation 3 ☐ Removel from State 10/17/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 22. Name and Address of Facility Charles S. Zeiler &Sons. Inc. 6224 Eastern Avenue Baltimore, Maryland 21224 23a. Part1. Enter the disease, or completions that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fallure. List only no cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical . Acute Myocardial Infarction -2 hours Examiner Due to (or as a consequence of): Physician/Medical Examiner -a hours Ventricular Fibrillation Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) c. Polymyalgia Rheumatica 5 tenosis Spinal 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yee 2 No 3 Probably 4 Unknown Jemen410 þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation after death. Director 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end menner es steled.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, end due to the cause(s) and menner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Hospital or Attending Physician: To the Hospital of ithin 24 hours at the Funeral D manufactor is the Funeral D Registrar

**DHMH 16 Rev 6/95** 

Box 68760,

P.O.

Division of Vital Records.

Jarique Firozvi 31. Date filed (Month, Day, Year) OCT 1 7 2000

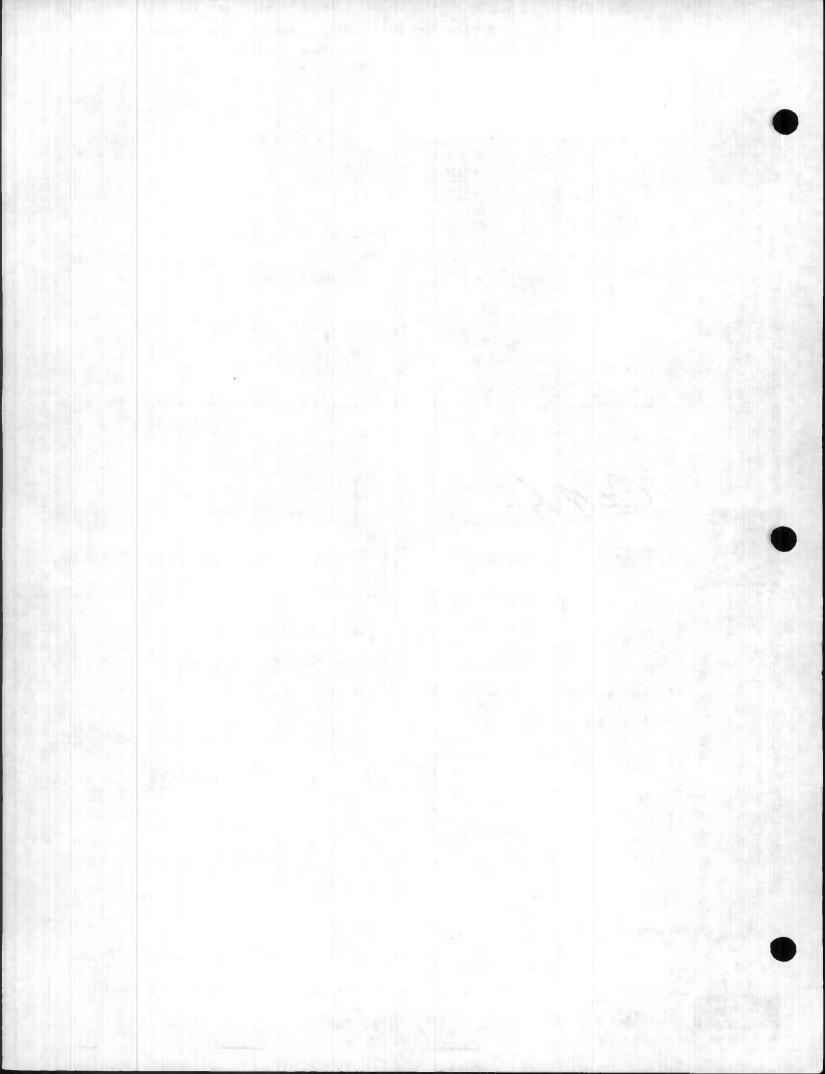
32. Registrar's Signature

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

MD

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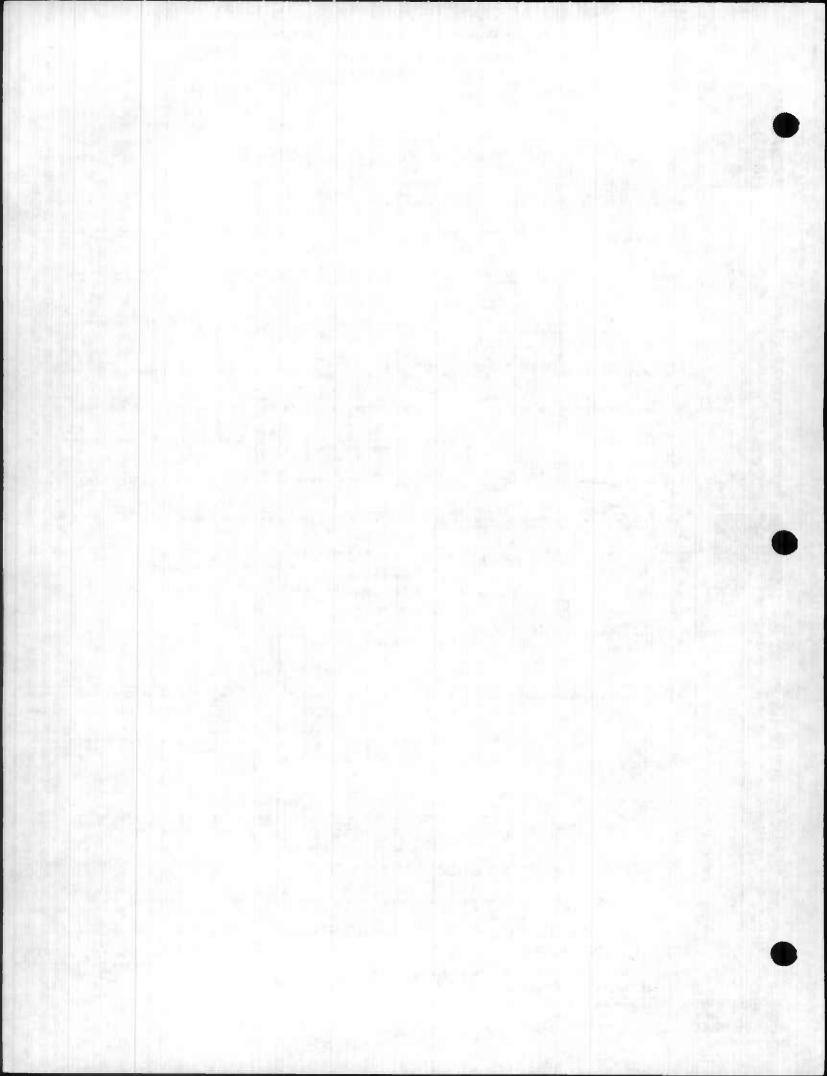
223 Eastern BLVD Baltimore Maryland 21221



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							Certi	ficate	of	Death		Re	g. No.		20	1.1
	Dia state		1. Decedent's Name (First, Middle	Last)			4,411					2. Date of Deeth Month	Day	Year	3. Tim	e of Death
8	Physicia /Medica	_	ROBERT	CALVIN			CLA!	TTERE	BUCE	(		OCTOBER		000	6:	50 PM
	Examine		4a Facility Name (If not institution	give street and	number)				4	b. City, To	wn, or Lo	cation of Death	4c. County	of Death		
			7630 B & A BOUL	EVARD						GLEN	BURN	NIE	Al	NE A	RUNE	EL
	Funeral	1	5. Social Security Number	6. Sex 1)∑M 2□ F		(In yrs. last		f Under 1 fonths	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,				ate or Foreign
	Director	-	226-10-6359 Usual Residence of Decedent			0-1						MAY 3,	1916	VIRG	INIA	1
	Mend Mend		10a. State 10b. County			10c. City, To	own or Locat	ion		No.			9	1	Od. Insid	le City Limits
	Me	ō	MARYLAND ANNE	ARUNDEL		GI	EN_BU	DNIE							10	Yes 2 No
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	ith with the Merylen 23s or 28s-f show		7630 B & A BOUL	EVARD					210	061			U	S.A.		
	therma :	Funeral	11. Marital Status	12. Wes De	ecedent E Forces?	ever in U,S.	13. Wa	s Decede	nt of H	ispanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		e - Americ k, White,		n,
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altimore	8 = 5		20a. Method of Disposition  1X Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp.		m State	ceme	VELL C	ory or oth	er plac	ce)	110	D/18/200	O PORT DI			
alt	Depertment Paceurit. Paceu		21. Signature of Funeral Service I	ісерсея	>		22. N	lame and	Addre	ss of Facili	ySIN	GLETON F	UNERAL	HOME	, P.	Α.,
m	20529		Malle	le -			1 S	ECONI	D A	VENUE	, S.V	W., GLEN	BURNI	E, MD	. 21	061
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications the	et ceused	the death. D	o not enter t	the mode	of dyin	g, such as	cardiac o	or respiratory arre	st,		Approx	Between
	Physician			^											Onset	and Death
	/Medical Examiner		Immediate Cause (Final disease or condition	. 17	201	fat	e	an	~	n				i	8	years.
	SALES IN		resulting in death)		-	fat Due to (or as	e conseque	nce of):	1							)
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ō	Physic rithis and district dis	9	27. Manner of Death	28a. De	te of Injur	y 28	b. Time of	28	_			28d. Describe ho			<b>y</b> /	
O	ding fth.	5	1 Cheturel 5 Pending		onth, Day	Year)	Injury	М		k? Yes 2□	No					
Division	or Attending after deeth. Director: Afte d in by the fune	200	3 Sulcide 6 □ Could n	ned   200. Pie	ace of Inju	ry - At home	, farm, street	t, factory,	office			28f. Location (St		ber or Run	el Route	Number,
ā	or A siter	Certification:	4 ☐ Homicide	ьи	liding, etc	. (Specify)						City or Town	, State)			
	Hospi 24 hou Funer stely fill			xaminer: On the		examination						and due to the ca red at the time, da				use(s)
	within 2		29b. Signature and title of certifier					29c.	Licens	e number		25	d. Date signe	d (Month,	Day, Ye	ar)
	1 10		Mar	uan					7	29 5	505	1	Actob	ses.	16.	2000
	(01)	-	30. Name and address of person v	no completed or	ause of do	ath /ttem 22	a) (Type Pri	int)	10			0.1		-		
,	12		Yndhbh	Mari	an	16	00	Coa	uv	th	vy,	Glen	Bu	mi	C, N	21061
	Stat Registra	е	31. Dete filed (Month, Day, Year) OCT 1	7 2000	. registra	ar's Signature										

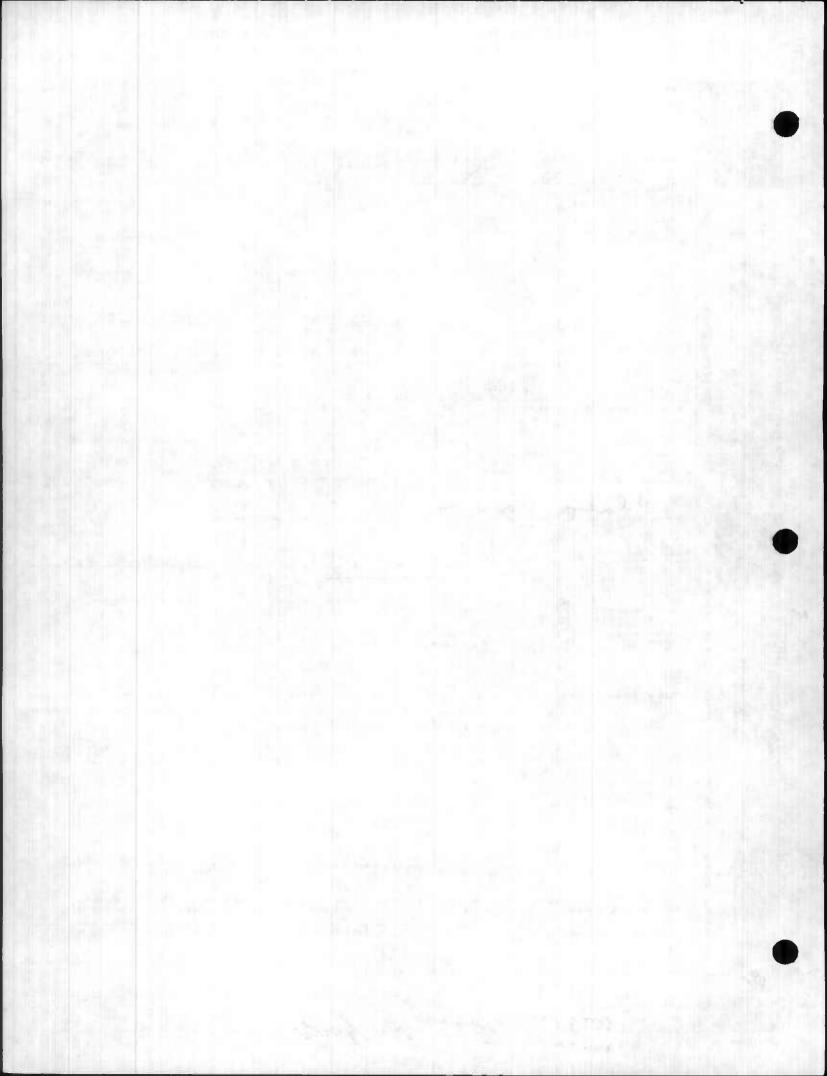
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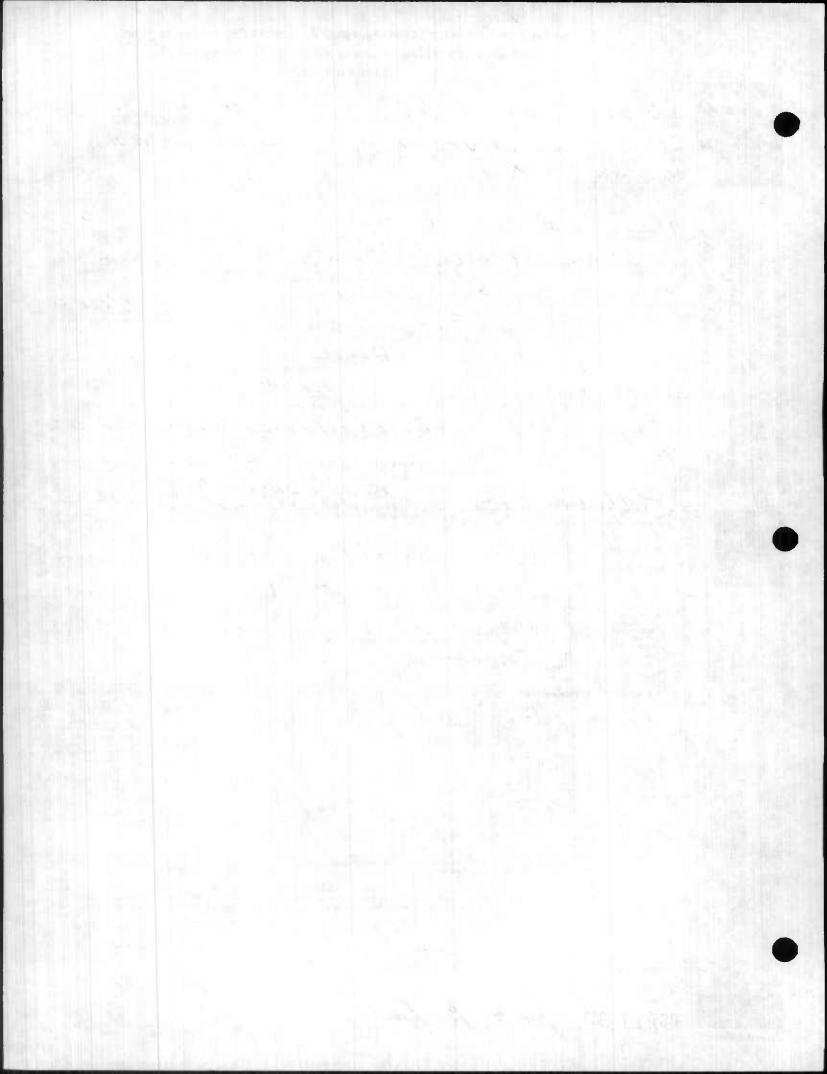
of Maryland / Department of Health and Mental	l Hygiene	00	326	7
Certificate of Death	4000000			

Physician /Medical Examiner  Funeral Director	Sylvester 4a Facility Name (If not institution, give street end number)	Cherr	V		Month	Dey	Year
Examiner Funeral	4a Facility Name (If not institution, give street end number)		4		October	15	2000 10:15 A.
_				4b. City, Town, or Loc		4c. County	
_	Johns Hopkins H	Hospital		Baltimo			N/A
rifector	1 N 2 T E	ge (In yrs. last birt	hday) If Under 1 Yeer Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day, Y. Ol-21-	36	9. Birthplece (State or Foreign Country)  NC
i u	10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limit
fled a	MD NA	Balti	more				1√ Yes 2□N
or 28a-1s be notified	10e. Street and Number		10f. Zip Code	-38	10g	. Citizen of W	hat Country?
	2007 E. LaFayette Aver	nue	2121	3		USA	
Examiner must Examiner must by Furneral	11. Meritel Stetus  1 Never Merried 2 Merried  3 Widowed 4 Divorced  12. Wes Decedent Armed Forces?  1 Yes, Give Yeer or Detes:	Ever in U,S.	13. Was Decedent of H If Yes, specify Cub	tispenic Origin? (Specen, Mexican, Puerto F Specify:	city Yes or No- lican, etc.)	Bleck	- American Indien, k, White, etc.
dical dical	15. Decedent's Education (Specify only highest grade completed)	16e.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	eation during most of workin	16	b. Kind of Bu	siness/Industry
d other than "naturn event, the Medical.] Be Completed	Elementary/Secondary (0-12) College (1-4or S IOth Grade NA	5+1	life. DO NOT use retire ment Fini			ozanh	1110877
Co Pr		Ce	ment rini	18. Mother's Neme		-	Averza
	17. Father's Neme (First, Middle, Last) Walter Cherr	C V		Vivian	ir irsi, imiddie, Ma		lliam
To	19e. Informent's Neme/Reletionship (Type, Print)		Mailing Address (Street		Route Number C		212
r trau	Allene Cherry						more, Mary
40	20e. Method of Disposition	20b. Plece of	Disposition (Neme of				City or Town, Stete
0	1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)		y, cremetory or other ple Zion Ceme		21-2000	Lans	downe MD
Table of	21. Signeture of Funeral Service Licansee			-			land 21202
111	b u o a						
	23a. Pert1. Enter the disease, of complications that caused	d the deeth. Do n	WM.C.Mar				Approximate Interval Between
for use as the bunial-transit of the state of the bunial-transit of the bunial-transit of the state of the st	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or es e c					
igned by the attending be detached for use a by Physician/M	Part II. Other significant conditions contributing to death b	out not resulting in	the underlying cause given	ven in Pert I.			tribute to the cause of dea
y Ph					1 Yes	2 ⊔ No	3 ☐ Probably 40 Unkn
uld be d					24e. Wes en e		24b. Were autopsy finding eveilable prior to
page 2 should be Completed					Inspec		completion of cause of deeth?
rector, page 2.					~	2(XNo	1 ☐ Yes 2 No
Be C	25. Was case referred to medical			26. Place of Deeth			
9	exeminer? 1 ☑ Yes 2 ☐ No Hospitel: 1 ☐ Inpatie	ent 2 DER/Out	tpatient 3 DOA Ott	207	e 5 Residenc	e 6 □Othe	er (Specity)
unera On:	27. Manner of Death 1 Neturel 5 Pending (Month, Da	y Year) 28b. T	njury Wo	ry et 2 rk? Yes 2 No	8d. Describe how	injury occurr	ed
completely filled in by the funera Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Plece of Injuiciding, etc.	jury - At home, fer c. (Specify)	rm, street, fectory, offica		8f. Location (Stree City or Town,	et and Numbe Stete)	er or Rural Route Number,
cal Ce	29a. Certifier  (Check only  20 Medical Examiner: On the basis of	of my knowledge	deeth occurred at the til	me, dete end plece, e	nd due to the caus	se(s) end me	nner es stated.
mpletaly fill	one) and manner sto	eted.					
2	290. Signature and title of diretting	er d	1 29c. Licens	.C.M.E.	290		(Month, Dey, Year) Der 15, 2000
	30. Name and address of person who completed cause of d	leeth (Item 23a) (					
,	and the state of t	3.3	1 5 61				
	Joseph Pestaner, M.D.  31 Data fied (Moon Day, Year) 32. Registr	er's Signeture	1 Penn Stre	et, Baltın	ore, Mar	yland	21201



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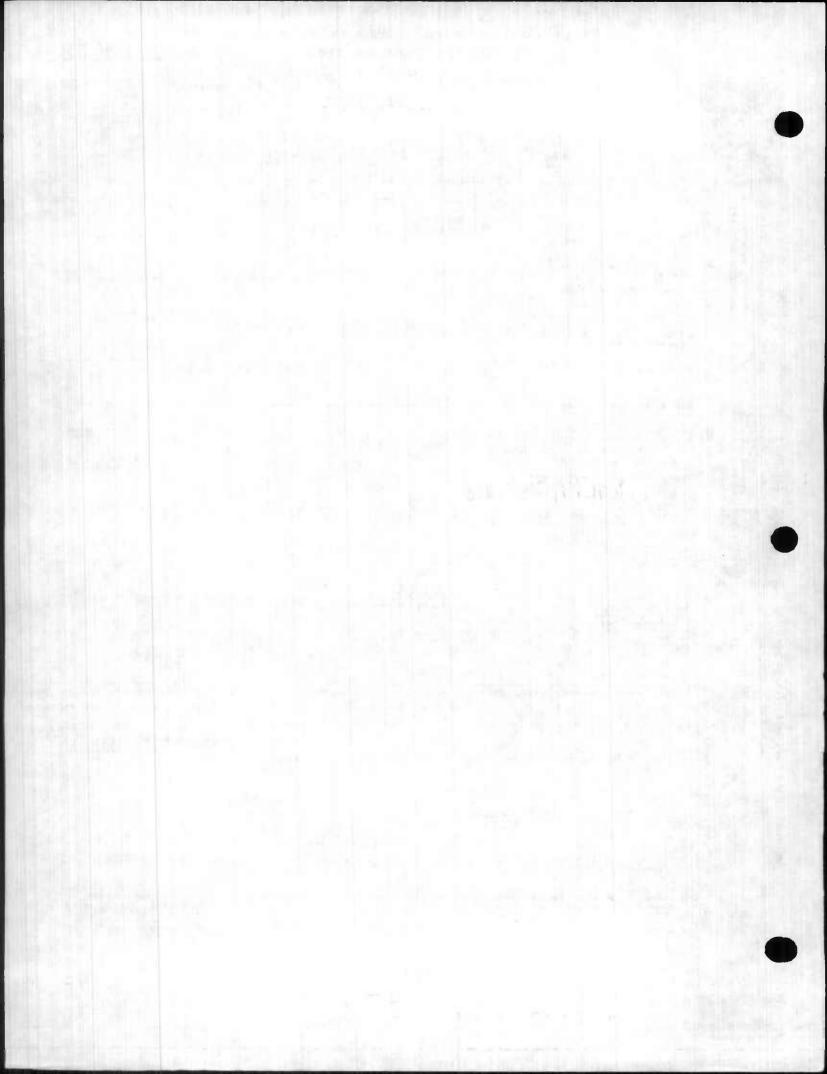
				Certificate of Death	Reg. No.				
			Decedent's Name (First, Middle, Last)	1	2. Dete of Death Month Dev	3. Time of Deeth			
	Physicia /Medic		Dorothy L. Col	ev	10 - 13- 2	10:54/10			
Ä	Examin		4e Facility Name (If not institution, give street end number)	4b. City, Town, or L		of Deeth			
			Johns HOPKINS BAINIEW	Central	110.	VIA.			
П	Funeral		5. Social Security Number 6. Sex 7/Age (In yrs. last I	birthdey) If Under 1 Year If Under 24 Hrs.  Yrs. Months Deys Hours Min.	8. Dete of Birth (Month, Dey, Year)	Birthpleca (Stete or Foreign Country)			
L	Director		Usual Residence of Decedent	116.	July 20,195)	N.C.			
	72 hours efter deeth with the Maryland natural, or thems 23s or 28s-f show stell Examiner must be not find at			own or Location		10d. Inside City Limits			
		to	$m\Omega$ , $M/A$ .	BA 118.		1 PYes 2 No			
	h the	Directo	10a. Street and Number	10f. Zip Code	10g. Citizen of W	/het Country?			
	th wit	aio	3623 RAVENWOOD AVE	21213	21.	5.A			
	Herra Herra	Funeral	11. Meritel Stelus  12. Wes Decedent Ever in U,S. Armed Forces?	13. Wes Decedent of Hispenic Origin? (Sp tf Yes, specify Cuben, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Rece	- American Indian, k, White, etc.			
20	of the series	by Fu	1 Ves 2 No If Yes, Give	1 ☐ Yes 2 ◯ No Specify:	Specify	KILLE			
5-0020	natural',		3 LJ Wildowed 4 LI Divorced Yeer or Detes:	Se. Decedent's Usual Occupation	16h Kind of Bu	DITECT SINESS/Industry			
15		Completed	(Specify only highest grade completed)	(Give kind of work done during most of work life. DO NOT use retired)	ring	an loos in loosiny			
212	within iene.	E O	Flementery/Secondary (0-12) College (1-4or 5+)	Nurse	Hos	01			
PC	end Mentel Hygie end Mentel Hygie s marked other aumatic event, in	BeC	17. Father's Neme (First, Middle, Last)	18. Mother's Nem	e (First, Middle, Maiden Sumem	8)			
/lar		0	John Price	Lilli	e poley				
lan			19e. fnformenl's Neme/Reletionship (Type, Print)	9b. Meiling Address (Street end Number or Ru	rel Route Number, City or Town,	Stete, Zip Code)			
Z.	end 2 Balth n 27 i		TONIKA CORY	3623 KAVEN WOO.	el AVE BALTO	· mr -2/2/3			
ore	of H		20e. Melhod of Disposition  1 ■ Buriel 2 □ Cremetion 3 □ Removel from Stete	of Disposition (Neme of tery, cremetory or other place)		City or Town, State			
E	ment ment jury		4 □ Donetion 5 □ Other (Specify) (1000)		10-1920 BATTO				
Balti	Depart Depart Import eny inj		21. Signature di Funeral Service Licensee	22. Name and Address of Fecility BeTIS Func	not Home				
_	jt.		Jaluera Bells	1129 N. CARO 11.	16 31.15400	5 Mr. 21113			
1			23a. Part. Enter the disease, or complications that caused the deeth. D shock, or heart failure. List only one cause on each line.	o not enter the mode of dying, such es cardiec	or respiretory errest,	Approximate Intervel Between Onset end Death			
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	Examiner		disease or condition e. Sudden C	ardiopulmonary Arrest		Immediate			
	d d ansit	Jer	Due to (or es e consequence ot):  Stevoid dependant asthma Year;						
		Examiner		a consequence of):	1 M a	10009			
0	be executed ician and burial-transit		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	2	Years				
Due to consequence of:									
		Medi	Years						
Вох	death cer e ettendir ed for use	Physician/	d						
P.O.	the de	ysic	Part II. Other significant conditions contributing to death but not resulting	In the underlying cause given in Pert f.		23b. Did tobacco use contribute to the cause of death?			
	law requires that the de as been signed by the 2 should be detached		Hyperlipidemia		1 Yes 2 No 3 Probably 4 Unknown				
Vital Records,	sign Id be	d by			24e. Wes en eutopsy	24b. Were eutopsy findings			
00	should should	lete			performed?	eveilable prior to completion of cause of death?			
Re	0 - 0	Completed			1□ Yes 2 No	1□ Yes 2□ No			
ita	ician: Th certificate rector, pa	Bec	25. Wes case referred to medical	26. Place of Dee	th (Check only one)				
t <	0 0	2	examiner? 1 Yes 2 No Hospitel: 1 Inpatient 2 FRA	Outpetient 3 DOA Other: 4 Nursing H	Other				
n of	Attending Physical Attention of death.  Sector: After this by the funeral		27. Menner of Deeth 1 Neturel 5 Pending (Month, Dey Year) 28a. Dete of Injury (Month, Dey Year)	o. Time of 28c. Injury at Work?	28d. Describe how Injury occurr	red			
Sio		catio	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No					
	- 9 5 -	Certification:	4 ☐ Homicide  determined  28e. Pleca of Injury - At home, building, etc. (Specify)	ferm, street, fectory, office	28f. Location (Street end Numb City or Town, Stete)	er or Rurel Route Number,			
	pltai prai filled		29e. Certifier 15 Certifying Physician: To the best of my knowled	les death convered at the time data and place	and due to the sever(e) and me	anner en eteted			
	To the Hospital or within 24 hours efte To the Funeral Dir completely filled in	edicai	29e. Certifier  (Check only one)  2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, and due to the ceuse end menner steted.						
	ro the ro the comple	Z	29b. Signature end title of cartifier	29d. Date signe	I. Date signed (Month, Day, Year)				
	1		29b. Signature end title of cartifier  29c. License number  29d. Date signed (Month, Day, Year)  10/16/00						
	N		D. Neme and eddress of person with completed cause of deals, ricern 23a; (Type, Print)  aura M Mumford, MD 10755 Falls Rd Lutherville MD 21093  1. Dete filed (Month, Dey, Year)  32. Registrer's Signeture						
	Sta								
	Registra	ir	OCT 1 7 2000 Benevit 15	Sparks					



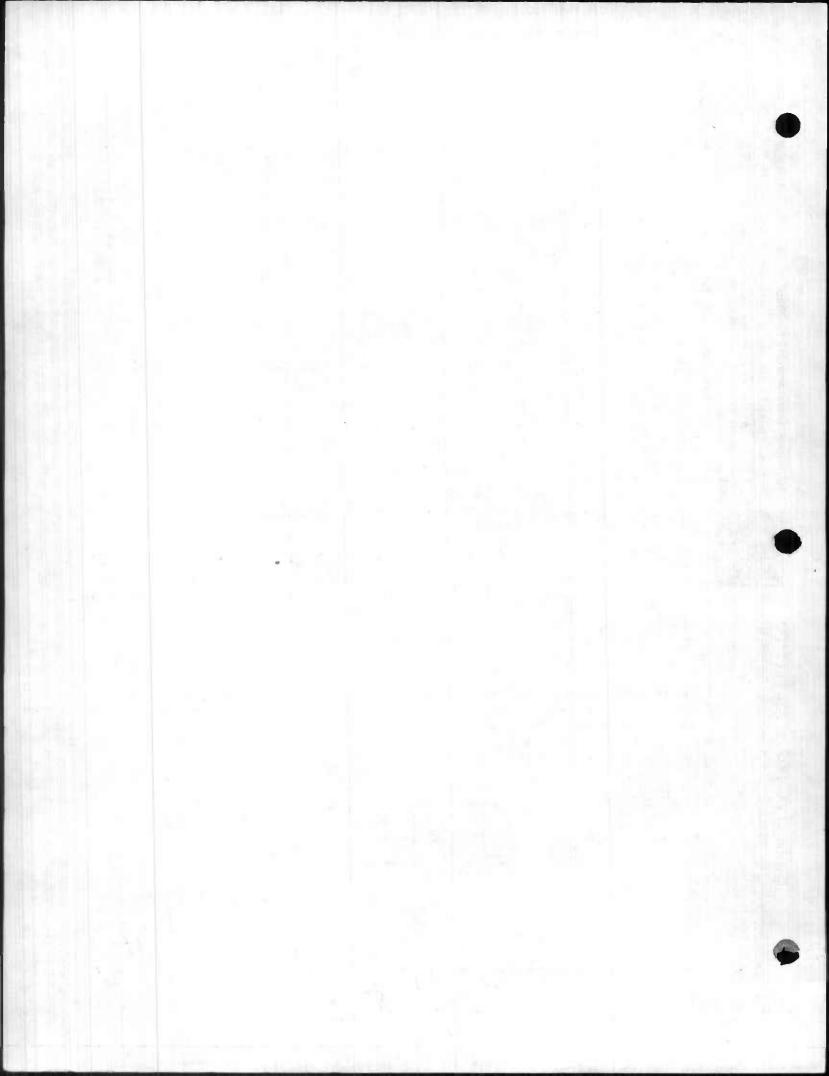
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State of Maryland / Department of Health and Mental Hygiene 0 0 3 2 6 8 0

		Certificate of Death	Reg. No.				
Physician	1. Decedent's Name (First, Middle, Last)	111001	2. Date of Death Month Day Yea	3. Time of Death			
/Medical		LANDRA ALSITY, TOWN, OF L	OCTOBER 11 200				
Examiner	The Johns Hoplans Hos	pital Baktim	orcCity N/A				
Funeral Director	5. Sócial Security Number 6. Set 7. Age (In yrs. laft) 62	hirthday) Yrs.  If Under 1 Year  If Under 24 Hrs.  Months  Days  Hours  Min.		Birthplace (Stata or Foreign Country) OPEA			
and and	Ususi Residence of Decedent  10a. State 10b. County 10c. City, To	own or Location		10d. Inside City Limits			
Ifter death with the Maryland r hems 23a or 28s-f show from must be notified as		Severn		1 ☐ Yes 2 No			
Nith th	1828 Cedar Lane		10g. Citizen of What Country?				
eath a 23	11. Marital Status 12. Was Decedent Ever in U.S.		USA merican Indian,				
D20 urs after Mf, or he	Armed Forces?  1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates:	P If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  No 1 Yes ¾□ No Specify:		Bleck, White, etc.  Specify: Asian			
72 hours	15. Decedent's Education (Specify only highest grade completed)	Sa. Decedent's Usual Occupation (Give kind of work done during most of work	16b. Kind of Busine	ess/Industry			
	Elementary/Secondary (0-12) Collega (1-4or 5+)	'life. DO NOT use retired) Cook	Food Se	ervice			
be filed to the Hygid other event, the Co	17. Fathar's Name (First, Middle, Last)		e (First, Middle, Maiden Sumame)				
should be and Mentel merked our metic even	Man Jo Ahn	Soon	n Ja Choi				
Maryland to 2 should be file lith end Mentel by 27 is marked oth To Be		9b. Mailing Address (Street and Number or Ru					
of Heelth or Hem 27 is other trau	Millie Parrott/Daughter 47	730 Hale Haven Drive	Ellicott City, M	D 21043			
Pege Pege ment of mrt: H	20a. Mathod of Disposition  1 Burial 2 (Cremation 3 Removal from State  4 Donation 5 Othar (Specify)  20b. Placa of Disposition (Nama of cemetery, crematory or other place)  Metro Crematory Inc.  20c. Location - City or Town, State  10-14-00 Baltimore, MD						
Baltimo	21. Signature of Funeral Service Ligansee MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD						
games (	23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.  230.1 Frederick Road Catonsville, MD 21228  Approximata Interval Batween Interval Batween						
Physician				Onset and Death			
/ /Medical Examiner	Immediate Cause (Final disease or condition rasulting in death)	3E	2 DAYS				
	Due to (or as a consequence of):						
owacuted on and riel-transit	U.	a consaguance of):		1 1377			
68760, ifficate be exact g physicien and as the buriel-in-	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):						
death death of for u	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23b. Did tobacco uss contrib	outs to the cause of death?			
ds, P.O. Box ires that the death certises that the death certised by the ettendir d be detached for use d by Physiclan/A		1 Yss 2 No 3 Probably 4 Unknown					
require should			24a. Was en autopsy performed?	4b. Were autopsy findings available prior to completion of cause of death?			
The law ate hes page 2			1□ Yes 2⊠No	1 Yes 2 No			
Yelclan: Thy yelclan: Thy secretificate director, pag	25. Was case rafarred to medical 26. Placa of Death (Check only ona)						
T digital	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
ding Ph After th funeral	1 Natural 5 Pending (Month, Day Year)	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work?  M 1 Yas 2 No		Bd. Describe how injury occurred			
r Attendant frector: n by the	2 Accident invastigation 3 Suicide 6 Could not be datarmined 28a. Place of Injury - At homa, building, etc. (Specify)	28a. Place of Injury - At homa, farm, street, factory, office 28f. Location (Street and Number or Rural Routa N		r Rural Routa Number,			
DIVISION To the Hooptal or Attendaming within 24 hours after death ompletely filled in by the Medical Certificat	29a. Certifier (Check only   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)						
the lithin 2 or the l	one) and manner statad.  29b. Signature end title of certifier	29c. License number	29d. Date signed (M	fonth, Day, Year)			
<b>1</b> 3 5 8	I Ande let M	D RES - 000	011				
30. Name and address of person who combinated cause of death (Item 23a) (Type, Print)  ANDREAS R LUFT 600 N, WOLFE ST BALTIMORE MD 21287							
State Registrar	31. Date filed (Month, Day, Year)  OCT 1 7 2000  32. Registrar's Signature	& Spain					



		State of Maryla		e of Death	Reg	j. No.	32681
Physician /Medical	Decedent's Neme (First, Middle, La	rhomas P. Carp	enter		2. Date of Death Month OCT 14	Dey Yeer . 2000	3. Time of Death 7:05am
Examiner Funeral Director		Health & Reh	aab. Center  Last birthday)  Yrs.  H Under Months	Annapo	8. Dete of Birth (Month, Day, Y	(ear) 9. Birtl	Arundel  Aplace (State or Foreign unity)  SSISSIPPI
ylend	Usuel Residence of Decedent  10a. Stele 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits
vith the Mar t or 28a-f a be notified Director	Maryland Anne Anne Anne Anne Anne Anne Anne An	cundel	Annar		100	. Citizen of What Co	1 ☐ Yes ZZ No untry?
23a o	6303 River Creso	cent Drive		21401		USA	
5-0020 72 hours after deeth with the Maryland natural; or Nams 23a or 28a-f ahow teal Examinar must be notified as	11. Meritel Status  1 Never Married 2 Merried  3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes:	U,S. 13. Wes Deced	ent of Hispanic Origin? (ify Cuban, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	14. Race - Amer Bleck, White Specify:	
	15. Decedent'a E (Specify only highest gri Elementery/Secondary (0-12)	ducation ade completed)  College (1-4or 5+) 5+	16a. Decedent's Usue (Give kind of wor life. DO NOT us Professo	ol Occupation the done during most of was retired)	orking 16	Sb. Kind of Business/	
	17. Fether's Neme (First, Middle, Last		Troresso		eme (First, Middle, Ma	College (iden Sumeme)	
aryiand 212: should be filed within nd Mental Hyglene. marked other than umatic event, the Mental To Be Comp	Unk.	Carpe	nter	Unk.		F	Patten
Ma 1223 Trac	19e. Informent's Neme/Reletionship ( Esther Carpenter			(Street and Number or I			
ges 1 and it of Health if Health or other tr	20a. Method of Disposition  1 □ Burial 2 ☑ Cremetion 3 □	20b.	Plece of Disposition (Nen cametery, cremetory or o	er Crescent ne of ther pleca)	Drive Ani	Dapolls, MacLocation - City or	ID Z14U1 Town, Stete
F S S S S S S S S S S S S S S S S S S S	4 Donetlon 5 Other (Special	y) Me	tro Cremator	y, Inc.	10/16/00	Baltimo	ore, MD
Balt permit. Depart import any inje	21. Signeture of Erneral Service Lice	M) Gemand	299 Fr	Address of Fecility ion Society ederick Roa	ad Baltimo	ore. MD 21	228
Physician	23a, Pert1. Enter the diseese, or com shock, or heart feilure. List only	plications thet caused the decore cause on each line.	eth. Do not enter the mod	e of dying, such es cardi	ac or respiretory arres	ι,	Approximate Interval Between Onset end Deeth
/Medical Examiner	Immediate Cause (Finel disease or condition resulting in deeth)		nary Ari	ery dis	ease	 	XIS
ait ed		b. HV	(or as e consequence of):	100			415
.O. BOX 68760, the death certificate be axecuted whe attending physician end sched for use as the bunk-transit hysician/Medical Examiner	Sequentially list conditions, it eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	C	(or as a consequence of):				
at the deeth certiful by the attending etached for use etached for use Physician/M	Part II. Other significant conditions of	contributing to death but not re	sulting in the underlying c	ause given in Pert I.	23b. Did tob	acco use contribute	to the cause of death?
as that the de igned by the be detached by Physic					1 ☐ Yes	2 No 3 P	robably 4 Unknow
ecord aw requir ts been s 2 should pleted					24a. Wes en performe		Were eutopsy findings evailable prior to completion of cause of death?
Con Con					1□ Yes	2 No	1 ☐ Yes 2 ☐ No
Of VItal I Physicien: The this certificate ral director, page To Be Co	25. Wes case referred to medical examiner?	Hospitel: 1 ☐ Inpetient 2[	☐ ER/Outpatient 3☐ DC	Other	eeth (Check only one) Home 5 Residen		oifu)
VISION OF Attending Physic death.  ector: Attenthis by the funeral of iffication: Te	27. Menner of Death  1 Netural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		8c. Injury at Work?	28d. Describe how		ony)
2 94 4 E	3 Suicide 6 Could not be determined	28e. Placa of Injury - At building, etc. (Spec	home, ferm, atreet, fectory ify)	, office	28f. Location (Stre City or Town,	et end Number or Ru Stete)	urel Route Number,
Hospi 24 hour Funer tely fill	29a. Cartifier 1 Certifying Pt (Check only one)	nysician. To the best of my kn niner: On the besis of exemin and menner steted.	owledge, deeth occurred ation end/or investigation,	et the time, date and pla in my opinion, deeth oc	ce, end due to the cau curred et the time, dat	ise(s) and menner es e end plece, and due	stated. to the ceuse(s)
To the within 2 To the comple	29b. Signeture and title of certified	M.N.	290	License number  04197	290	Date signed (Month	h, Dey, Year) -2000
y	30. Neme and address of person who	ampleted cause of death (Ite	om 23a) (Type, Print)	PDIG	herely	MD. 2	0785
State Registrar	31. Dete filed (Month, Day, Year)  OCT 1	32. Registrates Sign 2000 Sept.	nature	Spa i	1		

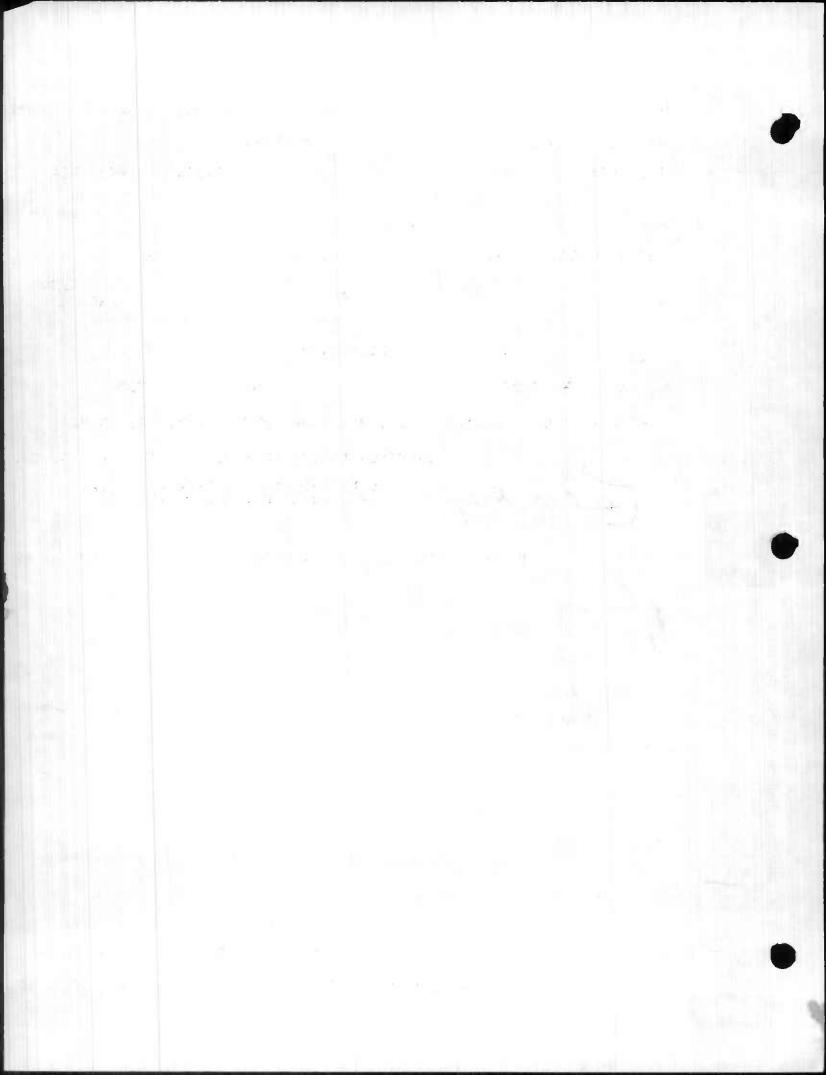


State of Maryland / Department of Health and Mental Hygiene 11 32682

					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ificate of			Reg. No.	, ,	2002
	Dharaialan	1. Decedent's Neme (Firs	t, Middle, Last)						2. Dete of D Month	eeth Dey	Yeer	3. Time of Deeth
	Physician /Medical	FRANCES		_		CUNNI	NGHAI		SEPTEN	BER 28	2000	04:23 M
	Examiner	4e Fecility Neme (If not in	stitution, give :	street end numb	er)				or Location of Dee	th 4c. County	of Death	
		HARBOR H						BALTIM				
	Funeral Dírector	5. Social Security Number 217 05 642	2 1	7.	Age (In yrs. 86	lest birthdey) Yrs.	Months Days		Hrs. 8. Date of B Min. 3/11/	orth Pey, Year)	9. Birthpi Coun VIR	lece (Stete or Foreign try) GINIA
	how		County		10c. Cit	y, Town or Loca	ation				10	Od. Inside City Limits
	ath with the Maryler 23a or 28a-f show and be not head	MD.				BALT	IMORE					1∰Yes 2□No
	or 28	10e. Street and Number	237				10f. Zip Code			10g. Citizen of \	Whet Coun	try?
	ath w							1225		USA		
020	hours effer death with the Maryland lural*, or thems 23s or 28s-f show Esant net must be not the death ed by Funeral Director	3# Widowed 4□D	Merried	12. Wes Decede Armed Force 1 Tes 2 If Yes, Give Year or Dete	s? ∄ No	1	es Decedent of Yes, specify Cu		? (Specify Yes or N uerto Rican, etc.)		e - Americ ck, White, o	
2-0	n 72 hours natural', notes Ex-	15. D	ecedent's Educ	cetion		16e. Decede	nt's Usuel Occi	upation e during most of red)	working	16b. Kind of B	usiness/Inc	dustry
21215-0020	withir ene.	Elementery/Secondary	7	College (1-40	or 5+)		ONOT use retir			НО	ME	
Maryland	lental Hygie ked other ic event, ti o Be Cc	17. Fether's Neme (First, I	Middle, Last) WINS	STON				18. Mother's	Name (First, Middle LUCY	e, Meiden Surnen WINS		
ary	N pund W	19a. Informent's Neme/Re	eletionship (Ty	pe, Print)		19b. Mailing	Address (Street	et end Number o	r Rural Route Num	ber, City or Town,	Stete, Zip	Code)
	alth alth 27 ls	WILLIE	AMOS	S SIS	STER	P.O.	BOX :	1258 T	WEST POI	INT, VA	. 23	181
ore	of Heal of Heal litem 2 r other	20a. Method of Disposition		amanal from Cha		Plece of Disposi cemetery, creme	story or other pa		Dete	20c. Location	City or To	wn, Stete
E	Pag int: In ry o	1 Buriel 2 Crer		emover from Sta	110	GARRIS	ON FOI	REST 10	0/3/2000	OWIN	GS M	ILLS, MD
Baltimore,	permit. Pa Depertment important any Injury phos.	21. Signeture of Funeral	Service License	0-4		22. E	Name end Add	ress of Fecility BROTHE	RS FUNER	RAL HOM	E P.	A .
	_	23a. Pert1. Enter the dise	ese or compli	cations that caus	sed the deet	h. Do not enter	the mode of d	ving, such es ce	rdiec or respiretory	errest.	414	Approximate
	Physician /Medical Examiner	shock, one of the shock of the		ACUTE	- MY	OCARDI or es a consequ		FAR C710	W		F	Interval Between Onset end Deeth
	be executed sicien and bunel-transit	Sequentially list condition		)	Due to (c	or es e consequ	ence of):			_	1	
ó		Sequentially list condition if eny, leading to immedia ceuse. Enter Underlying Ceuse (Diseese or injury thet initiated events	ite								i	
68760,	icate be expression is the burie	thet initiated events resulting in death) Lest	5 °		Due to (o	r es e conseque	ence of):				1	
	ng ph ng ph ses t	Toodking in dodain, Loss										
Вох	death cer e ettendin ed for use					-17					1	
	let the death cert d by the ettendin leteched for use Physician/M	Pert II. Other significant of	onditions con	tributing to deat	but not res	ulting in the und	terlying ceuse g	given in Pert I.	23b. DI	d tobacco use co	ntribute to	the cause of death?
P.0		DIABETES	MELL	17176					10	Yes 2□No	3 Prol	bably 4 diknow
S,	8 60 0			1100							24h W/	era autonou findings
Vital Records	The law requires set has been sign page 2 should be Completed by	HYPERTENS	SION						24e. We	es en eutopsy formed?	eve	ere autopsy findings eilable prior to mpletion of cause deeth?
Sec.	hes b									/	of	deeth?
H H	cete he page								10	Yes 2 No	1[	Yes 20 No
N It	yslctan: The is certificate director, pag Fo Be Co	25. Wes cese referred to examiner?		lospitel:				Wher:	Deeth (Check only			
o	hys his aldi	1 ☐ Yes 2 ☐ No  27. Menner of Deeth		1 1 mp		ER/Outpatient 28b. Time of	3LI DOA	4 LI Nursi	ng Home 5 ☐ Re	sidence 6 Oth e how injury occur		y)
Division	ling After fune fune	1 Natural 5 🗆 2 Accident	Pending investigation	(Month,	Dey Year)	Injury	28c. In W	ork? □ Yes 2 □ No		e now injury occur	160	
Divis	of in by the certificat	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined		Injury - At he etc. (Specif	ome, farm, stree y)	et, factory, offic	е		(Street and Num own, State)	ber or Rura	il Route Number,
	Hospi 4 hou Funer tely fill	29a. Certifier 1 C (Check only 2 N	ertifying Phye ledical Examir	end menner	of examine	wiedge, death tion end/or inve	occurred et the estigetion, in my	time, dete end p opinion, deeth	plece, end due to the concurred et the time	e ceuse(s) end m e, dete end plece,	enner es s end due to	teted. the ceuse(s)
	To the	29b. Signeture end title of	certifier	0			29c. Lice	nse number		29d. Date signe	ed (Month,	Dey, Year)
	10	* Yarw	γ.	Patel	4	- 02-) /T 0	DEA #	AS 244	1614-867	OCTOBE	RI	6 2000
H.	UNV	PAUNI PAT		mpleted ceuse of			rint)	10 2A	nic Jina	111-0 1-40	++	BANIMIRE
100	State	31. Dete filed (Month, Da)		32. Regi	strar's Signe	OSPITAL eture	CEN /	- 100	ואאוז כוני	116 JIV	tel,	()HU (IV)

State Registrar

OCT 16 2000

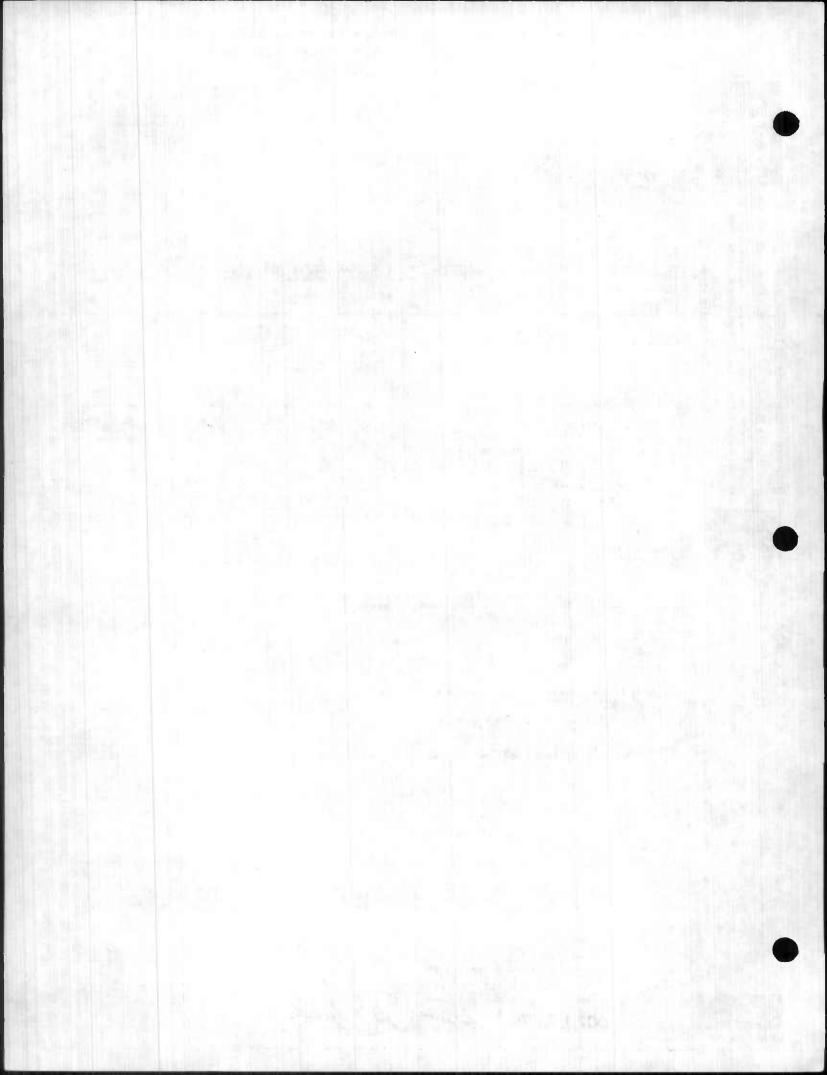


State of Maryland / Department of Health and Mental Hygiene 00 32683

			Certific	cate of Death		Reg. No.		
Dhuaisian	1. Decedent's Name (First, Middle, La	st)			2. Date of D Month	eath Day	Year	3. Time of Death
Physician /Medical	EDITH	J.	CAPL	AN	OCTOB		2000	3:30 AM
Examiner	4a Facility Name (If not institution, give				n, or Location of Dea			
	6900 MARSUE DRIV			BALTIM		BALTI	777	
neral rector	220-18-4164	Sex 7. Age (In )		Inder 1 Year If Under 2 hths Days Hours	Min. 8. Dete of B (Month, D)	irth ley, Year) 5,1927	9. Birthpla Country	ce (State or Foreig y) MD
	Usual Residence of Decedent  10a. Stete 10b. County	100	City, Town or Location				100	d. Inside City Limits
H H	MD BALTIM		ALTIMORE				100	1 ☐ Yes 2 ☑ No
be notified Director	10e. Street and Number	AKE E		f. Zip Code		10g. Citizen of	Man Causia	
	6900 MARSUE DRIV	Æ #T-2	10	21215		U.S.A		y '
by Funeral	11. Merital Stetus  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates;	If Yes,	ecedent of Hispantc Original Specify Cuban, Mexican, Mexi	in? (Specify Yes or N Puerto Ricen, etc.)		ce - Americar ck, White, et y:	
ted	15. Decedent's E (Specify only highest gro		16a. Decedent's	Usual Occupation	of working	16b. Kind of B	usiness/Indu	stry
Completed	Elementary/Secondery (0-12)	College (1-4or 5+)	COURT C	of work done during most of the control of the cont	or working	DISTRIC	T COUE	RT OF MD
Be C	17. Father's Neme (First, Middle, Last	)		18. Mother	's Name (First, Middle			
9 B	FRANK		GREENBERG	LENA	4	UNKNOWN )	)	
-	19a. Informant's Name/Relationship	Type, Print)	19b. Mailing Add	dress (Street and Number	or Rural Route Num	ber, City or Town,	, State, Zip C	Code)
at .	DAVID CAPLAN / H	IUSBAND	6900 MA	RSUE DRIVE #	T-2 BA	LTIMORE,	MD 21	1215
	20a. Method of Disposition		b. Place of Disposition	(Name of	Date	20c. Location		
5	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		cemetery, crematory ETH TFILOH		10/16/0	O MOODE	AWN,	MD
1	21. Signature of Funeral Service Line			ne and Address of Facility				
9000	1 Jain Ad	2		REISTERSTOW	SOL L	EVINSON PIKESVIL		
as the burial-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	C	o (or as a consequence					
Physician/M		d						
by Physician/	Part II. Other significant conditions of	contributing to death but not	resulting in the underly	ing ceuse given in Part I.				the cause of death
by Ph	Congestive	Heart Fail	ure			Yes 2 No	3 Probe	ably 4 Unknow
pietec	Atrial Fil	Heart Fail			24e. Wa	s an autopsy formed?	avai	e autopsy findings lable prior to spletion of cause seth?
раде					10	Yes 2 No	10	Yes 2□ No
director, page 2	25. Was cese referred to medical			26. Place	of Death (Check only	one)		
To E	examiner? 1 DYes 2 No	Hospitel: 1 Inpatient	2 ER/Outpetient 30	DOA Other: 4 Nur	sing Home 5 🛚 Res	sidence 6 🗆 Ott	her (Specify)	
	27. Manner of Death  1 DNatural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Yea.	28b. Time of Injury	28c. Injury at Work?		how injury occu	rred	
Certification:	3 Suicide 6 Could not be determined	e 28e. Place of Injury - A building, etc. (Sp	At home, farm, street, fa	actory, office	28f. Location City or To	(Street and Num own, Stete)	ber or Rural	Route Number,
completely filled in by the funeral Medical Certification:		ysician: To the best of my niner: On the basis of exam and manner stated.						
Me	29b. Signature and title of certifier			29c. License number		29d. Date signe	ed (Month, D	lay, Year)
1/0	1 Craige Hol	do		H 5308	38	october	13,20	000
57	30. Name and address of person who	completed cause of death (838 Greenet	Item 23a) (Type, Print)	135 Battir	more, Mai	uland 2	1208	
State	31. Date filed (Month, Day, Year)	32. Registrar's S	OTHER DESIGNATION OF THE PERSON OF THE PERSO	lai V				

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**ORIGINAL** 

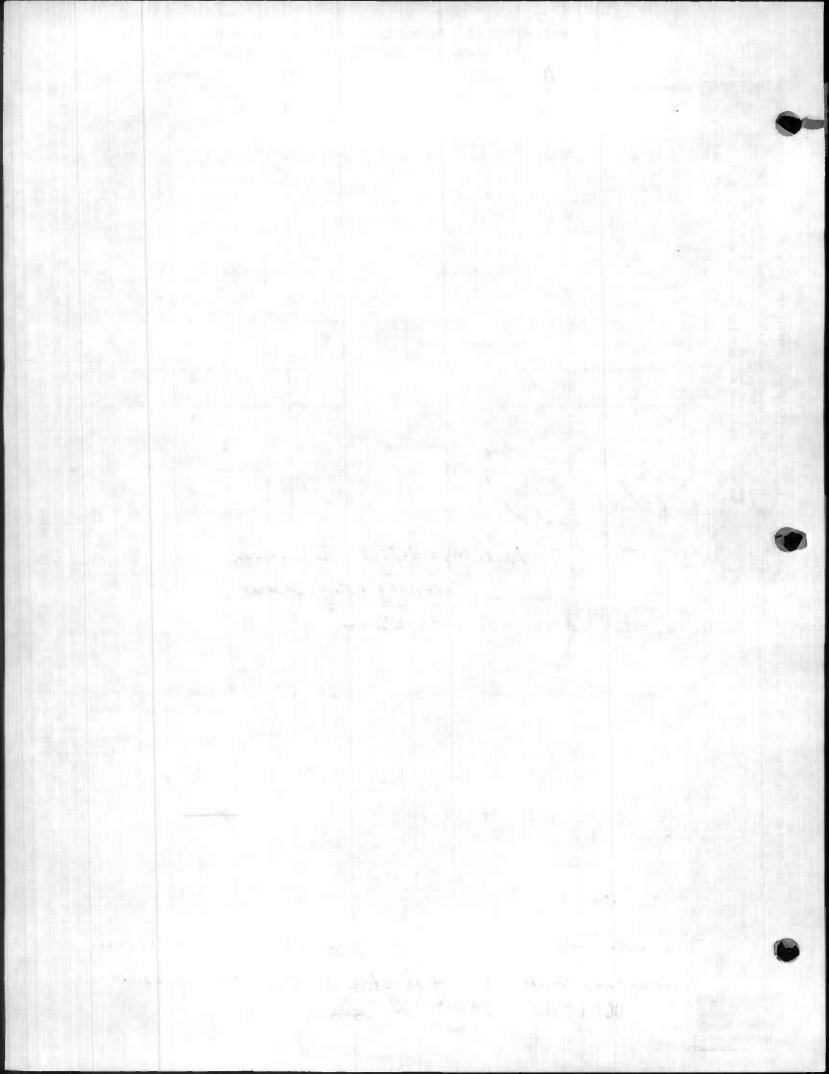


State of Maryland / Department of Health and Mental Hygiene UU

Certificate of Death Amended Item#26 per PhyG788 10 17/2000 EW 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3 Time of Death Dey Physician Lucille e. daniels OCT. 11,2000 9:10AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street end number) Examiner UNION MEMORIAL HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1□ M 2□ F Months Days Hours Yrs. 212-22-2972 73 Director OCT, 27, 1926 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show of 2 should be filed within 72 hours after death with the Maryle the end Maralla Hyglens. 7. I be marked other than "natural", or flarms 23a or 28e-f show traumatic event, the Maralla Eminion must be notified. 1 Yes 2 No Directo MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2621 AISQUITH STREET 21218 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11. Marital Status 1 Never Married 2 Married AFRO-AMERICAN Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: P 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) 12TH College (1-4or 5+) SEAMSTRESS MISTY HARBOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) DELOGIA CHAMBERS LUCILLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health end Important: if item 27 is many or other traum ROSA BENNETT (DAUGHTER) 4718 WILERN AVE. BALTO, MD. 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from Stete 4 Donation 5 Other (Specify) Arbutus Memorial ParkOctl7,2000Balto. MD 22 Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, on each line. Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or coupli shock, or heert teilure. List or Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) a. Acute myo caedial

Due to (or es a consequence of): Examiner Examiner attending physiclen and for use es the bunal-transit certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Hyper len sian Due to (or as a consequence of): Box 68760 Physician/Medical P.0. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the signed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 2 24a. Was an autopsy performed? 24b. Were autopsy findings Completed aveilable prior to completion of cause of death? certificate hes page 2 No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 💢 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 6 Residence 6 Other (Specify) 10 1XYes 2□ No After this 27. Menner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred or Attending Fetar deeth. 1. Netural 5 Pending investigation deeth. 1 Yes 2 No rector: / 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours of To the Funeral DI Medicai 12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) MTV D0021859 10.12.2000 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Baltimme MD 21222. 6710, HOLASIND AVE MOHAMMAD TARIMA 31. Date filed (Month Cay Year) State Registrar



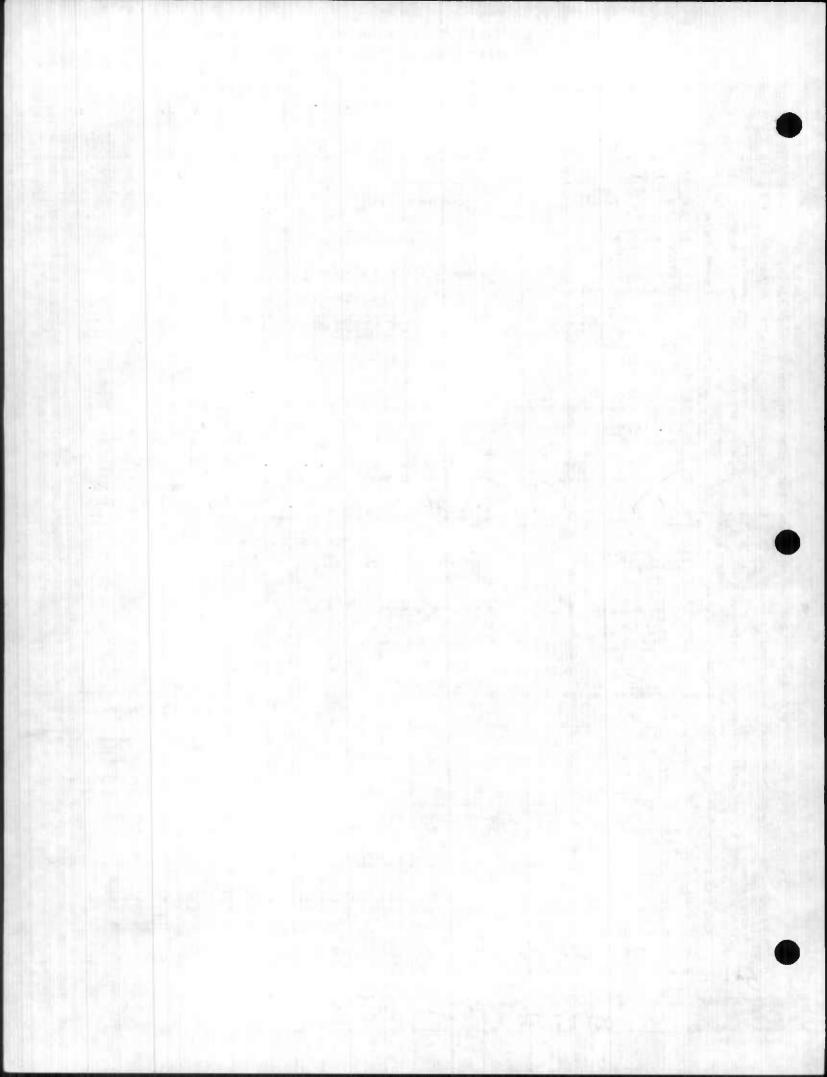
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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32685

			Ocitini	vale of	Death		Reg. No.	
Physiciar /Medica			seph Dig	nan,	Sr.	2. Data of De Month Octob	Day Y	3. Tima of Death (ear 2:00 PM
/Medica Examine	4a Facility Nama (If not Institution, give	va street and number)	3-55		4b. City, Town, or L			
Formula	7518 Ives Lane 5. Social Security Number 6.5	Sex 7. Aga (fn yn	s. last birthday) If I	Jndar 1 Yaar	Dunda:		th s	
Funeral Director		1 M 2□ F 80	Yrs. Mo	nihs Days	Hours Min.	(Month, De March	th Year) 27,1920	9. Birthplace (State or Foreign Country) Maryland
dend we	10a. Stata 10b. County	10c. C	City, Town or Location	n				10d. Insida City Limits
death with the Maryland rms 23s or 28s-f show rmss to notified at	Maryland Ba	altimore			Dunda	lk		1 ☐ Yes 21 No
or 28	10a. Street and Number 7518 Ives Lane		10	f. Zip Code			10g. Citizen of Wh	
fiter death with the Mar riters 23a or 28a-fe inter mat be confired	7 J16 IVES Edite	12. Was Decedent Ever in	II S 12 Was I	Decodent of		222		d States Amarican Indian,
T in the	11. Marital Status 1 □ Navar Marriad 2 ☑ Married	Armed Forces? 1 🛱 Yas 2 □ No			Hispanic Origin? (Span, Mexicen, Puert	Rican, etc.)	Black,	White, etc.
5-0020 72 hours after netural; or the second hours after the second		If Yes, Give Yaar or Datas: WW]		es 21X No	Specify:		Specify:	White
21215-002 ed within 72 hours of ygiene. The manufactural's, or the manufactural's, or	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Decedent's (Give kind	Usual Occu	pation during most of wor	king	16b. Kind ot Busi	
within she.	Elementary/Secondary (0-12) 5 Years	College (1-4or 5+)			perator		Fork Li	
Maryland 21215-0020 d 2 should be filed within 72 hours at th and Mentel Hygiene. T is marked other than "natural", or traumetic avent, tre Medical Extra	17. Father's Name (First, Middle, Last	)	FOIR I	JIIC O	-	ne (First, Middle	, Maiden Sumeme,	
aryland 2121 should be filed within and Mentel Hygiene. marked other than turnatic avent, use to					Anna	Dietz		
ire, Maryland 212 s 1 and 2 should be filed with f Heelth and Mentel Hygiene. Item 27 is marked other than other traumatic avent, trail To Be Common	19a. Informant's Name/Relationship (				et end Number or Ru	rei Route Numb ssville		
Para legi	Mrs. Deborah Hus		310 IV	(Name of		Date	20c. Location - C	
0 80=2	1 Sparial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specie	Removal from Stala	cemetery, cremetor	y or other pla				ngs Mills, MD
Baitin permit. Pa Departmen Important: any injury	21 Somure of Funeral Service Lice		22 Nor	no and Adde	one of Engility			
Depariment of the part of the	11/2 . (	1/			k Funeral e Ave. D			
	23a Part Enfar the disease, or com	plications that caused the da						Approximate Interval Between
Physician	Immediate Cours /Final		00 11		,			Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a.	elflodde	-	when Com	war		6 Month
		Oue to	(or as a consequence	e ot):				
oerificate be executed reing physician and use as the burial-transit	Sequentially list conditions,	b. Due to	(or as a consequence	e of):				
X 68760, certificate be executionate by secution and use as the burlal-transfer of the certification and the c	Sequentially list conditions, if any, laeding to immadiate couse. Enter Underlying Couse (Disease or injury that initiated events	c						
ox 68760, certificate be en ading physician use as the buria	that initiated events resulting in death) Last	Dua Io	(or as a consequanc	e of):				
ox ording use a use a		d						
dS, P.O. Bo	Part II. Other significant conditions of	contributing to death but not re	esulting in the underly	ying ceuse g	iven In Part I.	23b. Dld	tobacco use cont	ribute to the cause of death?
D'.O						10	Yes DNo	B □ Probably 4 □ Unknow
ords, P.C requires that the een signed by th hould be detach						24a Was	an autopsy	24b. Were autopsy tindings
The law require page 2 should in the control of the							ormad?	avaliable prior to completion of causa of death?
The law ate hes b						10	Yes DNo	1 ☐ Yas 🕶 No
Of Vital RECORDS, Physician: The law requires the sentificate has been signed and director, page 2 should be by TO Be Completed by					26. Piace of Dee		THE CONTRACT	
Of VITA Physician: this certific ral director,	examiner? 1 Yes 2 No		☐ ER/Outpatient 3	DOA O	ther: 4 Nursing H	oma 58 Ras	dance 6 Othar	(Specify)
Ing Pl	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		ury at ork?	28d. Describe	how injury occurre	d
DIVISION C tall or Attending P is after death. al Director: After ti ed in by the funera	2 Accident investigation 3 Suicide 6 Could not be determined	OB - Pleas et leius - At	home, tarm, street, t		Yas 2□No	28f. Location	Street and Number	or Rural Route Number,
DIV din b	4 Homicide	building, etc. (Spec	cify)			City or To	wn, Stete)	
DIVISION OF To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral of Macdinal Certification Tr	29e. Certifier 152ccertifying Pt (Check only one)	nysician: To the best of my kr niner: On the basis of examinand manner steted.						
o the vithin 2 on the comple	29b. Signature and title of certifier	and marmer steled.		29c. Licer	nsa number		29d. Date signed	(Month, Dey, Year)
F \$ F 0	> In Pentale	Then alice	erein	13/4	714		10/12/1	N
621	30. Name and address of person who	completed cause of death (ite				, ,	1.01	
7.	MILHARL PURTE	JABVAL	4940 1301	enr	AVE BA	LTI MORE	, md ?	4/224
State Registrar		32. Registrar's Sign	nature &	1				



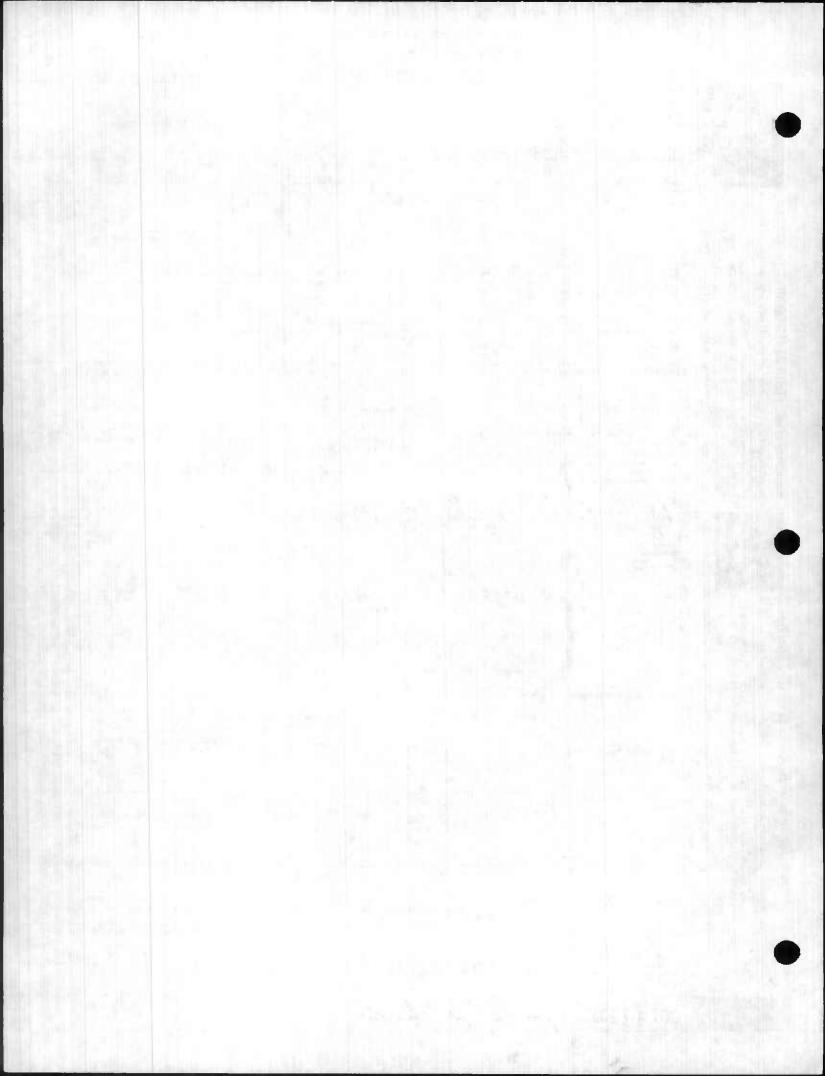
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Deeth **Physician** October 9 2000 William John Dempsey, Jr. 1702 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner St. Agnes Health Care Baltimore If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1♥M 2□F 71 Yrs. Director 218-22-5746 May 17 1929 Maruland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or flams 23a or 28a-f sho the Medical Examiner must be notified at 1 Yes 2 No MD Baltimore. Baltimore. Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1559 Clairidge Road 21207 USA Funeral 14. Reca - American Indian, Black, White, etc. . Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritai Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Auto Mechanic Auto Dealer permit. Pages 1 and 2 should be file.
Department of Health and Montal Hyg
important: If item 27 is marked any injury or other to any large. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) William John Dempsey. Sr. Mildred Marie Moon 19e. tnformant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Joan B. Dempsey- Wife 1559 Clairidge Road, Baltimore, Maryland 21207 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) October Woodlawn Cemetery 13,2000 Woodlawn, Maryland Name and Address of Facility Witzke Funeral Home, Inc. 630 Edmondson Avenue, Catonsville, Maryland21228 ons that obused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, assessment line. Approximete Interval Between Onset and Death Physician Immediate Ceuse (Finel disease or condition resulting in death) KESPIRATORY FAILURE /Medical Examiner CHRONIC OBSTRUCTIVE PriMONARY BISCAR Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last P.O. Box 68760. Physician/Medicai Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown SEVERE CONGESTINE CARBIAE FAILURE Division of Vital Records. py Physician: The law requires 24a. Wes an autopsy performed? Be Completed 24b. Were eutopsy findings CARSIAC ARRYTHMIA completion of cause of deeth? 1 ☐ Yes 250No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. tnjury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending investigation after death.

Director: Aff 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospius of With 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end menner stated. 29a. Certifier Medical 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signature/and title of certifier L MESSIEAL RESIBENT OCTOBER 16 2000 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) ALITU STAGNES LAKARI Y. 31. Date filed (Month, Dey, Year)
OCT 1 7 2000 32. Registrer's Signeture

DHMH 16 Rev 6/95

Registrar

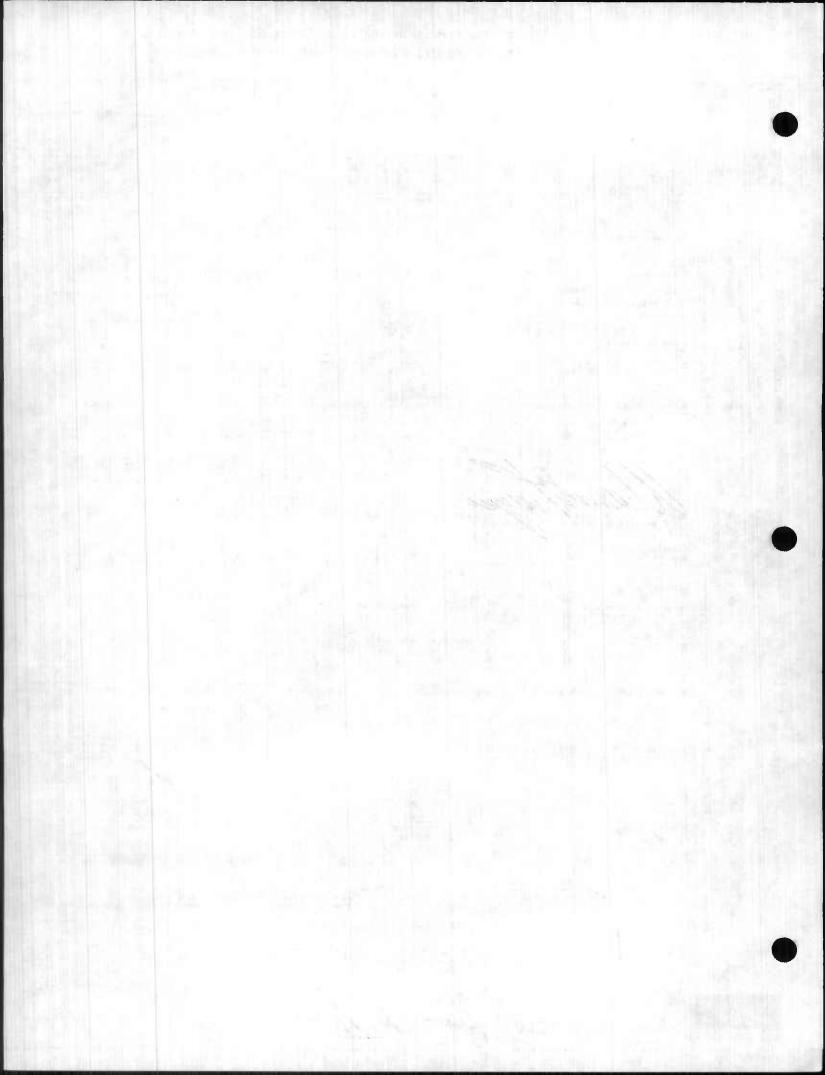


State of Maryland / Department of Health and Mental Hygiene

32687 Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death **Physician** amon 225PM 110 2000 Octobes 15 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not institution, give street end number) Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE 7. Age (In yrs. last birthdey) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sev **Funeral** Months Days 1□ M 2XF Hours Yrs. 100 Director 272-10-4645 OH Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2 No Director BALTIMORE 28e-t MD BALTIMORE must be notifi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 23a 6318 GREENSPRING AVENUE #303 21208 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 8 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Hygiene. other than filed within College (1-4or 5+) Elementery/Secondary (0-12) **HOMEMAKER** OWN HOME Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Be should be nd Mental marked o ELIJAH ROSE ETTA DANCEAU 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Pages 1 and 2 s mant of Health an ant: If Nem 27 is y ury or other traus 11 BRANCHWOOD COURT - BALTIMORE, MD 21208 EARL L. DIAMOND / SON Baltimore, 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 192 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) BALTIMORE, MD ARLINGTON CHIZUK AMUNO 10/16/00 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, on each line. Approximete Interval Between Onsat and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Sarcoma Examiner Due to (or as e consequenca of) Physician/Medical Examin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that included Due to (or as e consequenca of): Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by of Vital Records, 24b. Were autopsy findings available prior to complation of cause of deeth? 24a. Was an autopsy performed? Completed 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes Certification: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 1 | Inpatient 2 | ER/Outpatient 3 | DOA of Dout 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigat t GMatural 1 Yes 2 No after death 2 C Accident 6 ☐ Could not be 3 El Suicide 28e. Plece of Injury - At homa, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) ₹ 4 T Homicide 8 To the Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number 30. Name and addre af death (Item 23e) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar OCT 1 7 2000 **DHMH 16 Rev 6/95** 

ORIGINAL

11A1: 2 2 2000



#### Please Type or Print in Biack Indelible ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32688 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Cerrile Davis 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death JOSEPH RICHIE HOSPICE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/11/48 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) Days Months Hours 1□M 2#□F 52 216-50-9531 MD. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD. 1 ∰Yes 2 No BALTIMORE 10e. Sfreef and Number 10f. Zip Code 10g, Citizen of What Country? 1806 W. LOMBARD ST. 21223 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 # No AFRO 1 Never Married 2 Married 1 Yes 2 No Specify: Specify AMERICAN 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 12 0 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) ROBERT DAVIS FLOSSIE PUMPHREY 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ZANITA WILLIAMS 1806 W. LOMBARD ST. BALTO. MD. 21223 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete # Burial 2 ☐ Cremation 3 ☐ Removal from State MT. ZION CEM. Donation 5 Other (Specify) 10/10/2000 LANSDOWNE, MD. 22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A. 1200 FULLAW PL. BALTO. MD 21217 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24a. Was en eutopsy parformed? 24b. Were eutopsy findings available prior to completion of cause of death? 20 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Ho 5 ple 4 1 Yes 2 No 1 Inpatient 2 ER/Outpatienf 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide

physician and the burial-transit Box 68760 950 Po detached Division of Vital Records, P.O. signed by t been si certificate death.

Examiner Physician/Medical þ Completed Be i or Attend after death Director:

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

b

Nema 23a

b

"natural",

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "

any injury or

**Physician** /Medical

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Funeral

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traumatic event, the Medical Examiner must be notified at

death with the Maryland

Javis 10

P Certification: Hospital 24 hours a Funeral D edicai To the 6

29a. Certifier

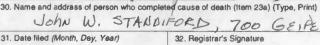
(Check only one)

29b. Signature and title of certifi

State Registrar

**DHMH 16 Rev 6/95** 

31. Date filed (Month, Dey, Year) 6 2000



🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

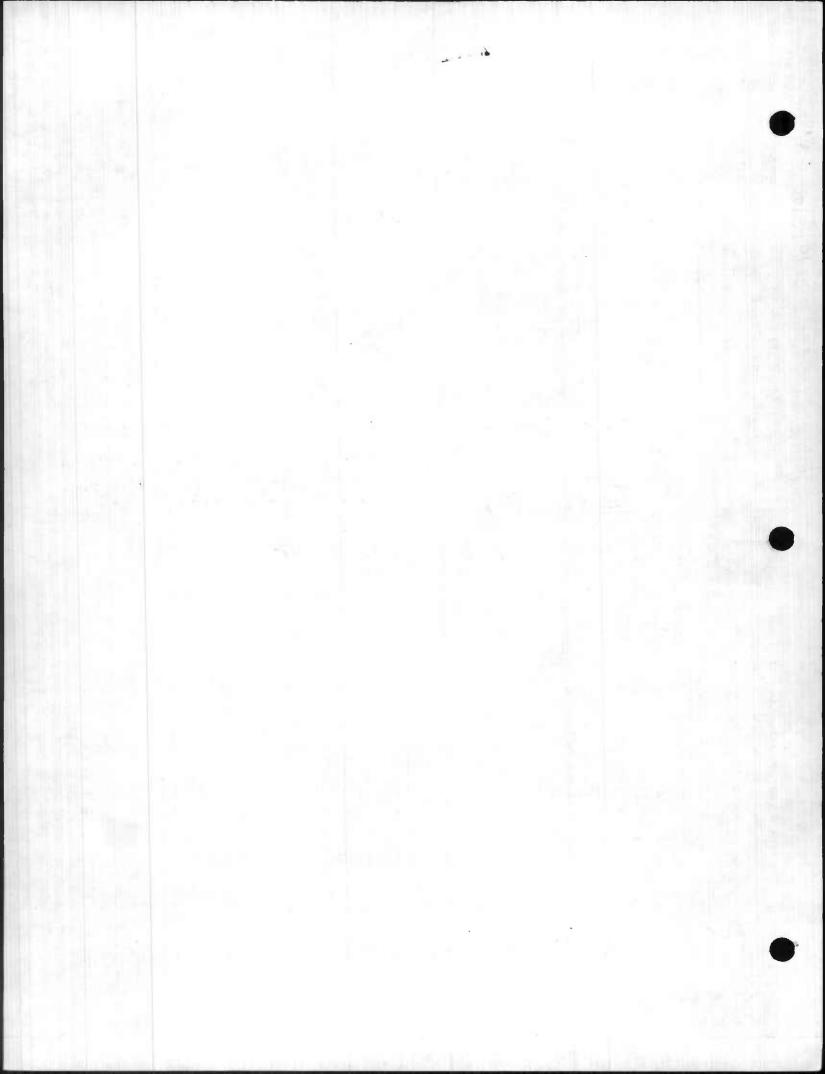
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

U0017386

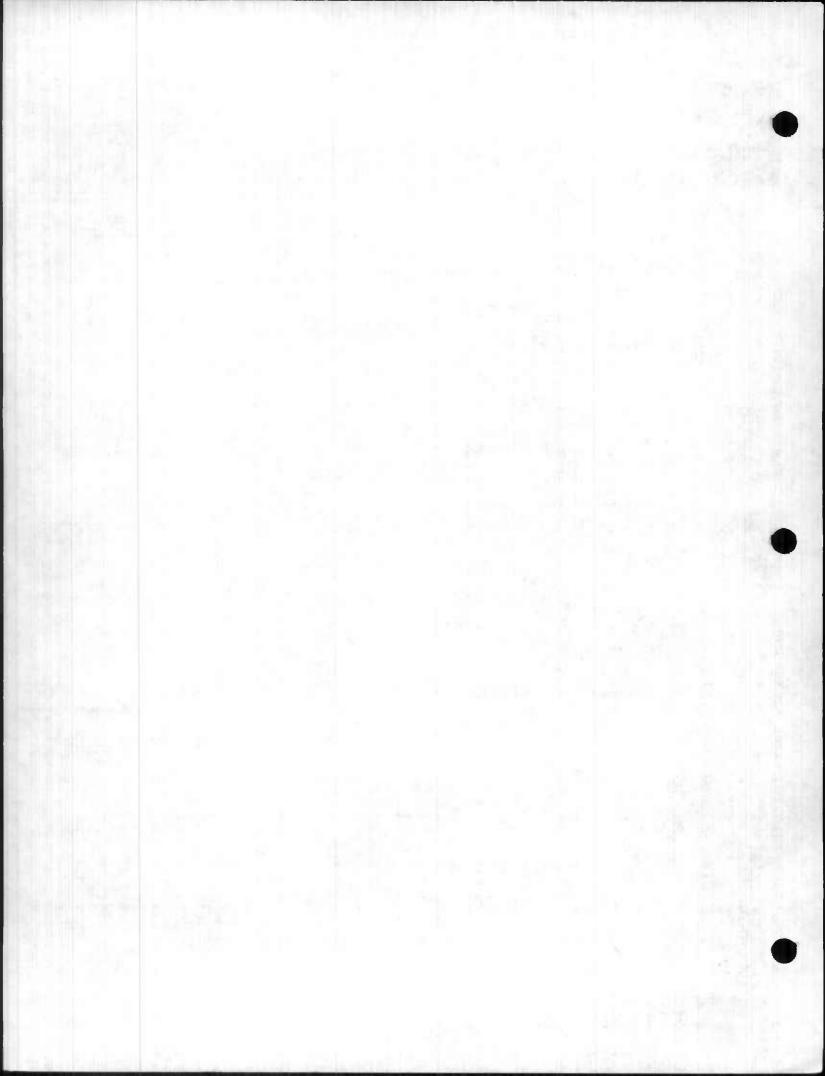
29d. Date signed (Month, Day, Year)

CAronsuille MD 21228



			State of M	aryland /	Certificate		lealth and M Death		giene [] [ Reg. No.	32	689
	1. Decedent's Ne	me (First, Middle, La	st)					2. Date of Dec Month	eth Dey	Yeer 3. 7	ima of Death
Physician /Medical	Fl	orence	Vivian	Fai	th				14, 200		8:30a.m
Examiner		(If not institution, given the colling w					4b. City, Town, or Loc Catonsv			of Deeth Limore	
Funeral Director	5. Social Security 213–22–		ex 7. Ag	je (In yrs. last t	Yrs. If Under 1	1 Yeer Days	Hours Min.	8. Dete of Birt (Month, De)		9. Birthplace ( Country) West Vi	State or Foreign
	Usuel Residence	of Decedent		10c City To	wn or Location	-				10d In	side City Limits
cmust be notified at neral Director	MD	Baltimo	ro		nsville						Yes 2X No
be notified	10e. Street and N		,IC	Cacc	10f. Zip (	Code			10g. Citizen of V	Vhet Country?	
D D		lling Wood	Road			2122	28		U.S.A		
iber must Suneral	11. Meritel Status		12. Was Decedent	Ever in U,S.	13. Wes Decede	ent of h	Hispenic Origin? (Spe	cify Yes or No-		e - American Inc	fian,
or the		rried 2 Married	Armed Forces?				an, Mexican, Puerto f	Rican, etc.)	Blac	k, White, etc.	
6 6	3 XWidowed	4 ☐ Divorced	If Yes, Give Yeer or Detes:		1 □ Yes 2	(XNo	Specify:		Specify	white	
t, the Medical	/Sn	15. Decedent's Ed		16	e. Decedent's Usuel	Occup	pation	20	16b. Kind of Bu	usiness/Industry	
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To Mile		Robert Dav									
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in the second		5 Other (Specif					gton Crem.				
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		ida XX	emmes		1630 I	<b>Edm</b>	ondson Ave	., Cato	onsville	, Md. 2	1228
	23a. Pert1. Ente shock, or he	r the disease, or com eert failure. List only	plications that cause one cause on each li	d the death. Do	not enter the mode	of dyi	ng, such es cardiac o	r respiretory as	rrest,	Inter	oximete vel Between
ician										Onse	et and Deeth
dical niner	Immediete Caus disease or condi resulting in deeth	tion	· Ga	ngrer	e consequence of):					1	
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sician and e bunal-transit cal Examin	Ceuse (Diseese that initieted ever	or injury	c	iabet						-	
	resulting in deeth			Due to (or es e	consequence of):						
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d for	Part II Other elgr	nificant conditions c	ontributing to death h	out not resulting	in the underlying ca	use di	ven in Part I	23b. Dld	tobacco use co	ntribute to the	cause of death?
deteched deteched			orthoding to double	at not rooding	in the disconying ou	idde g			Yes 2□ No	3 Probably	
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should b									an eutopsy	24b. Were au	topsy findings
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rector, page 2 should								10	Yes 2 No	1 ☐ Yes	2 No
o o	25. Was case ref	erred to medical					26. Plece of Deeth		/-	72.00	
- 0	exeminer?	ZNo	Hospitel:	ent 2 TER/	Outpetient 3 DO	Δ Oti	her:			er (Specify)	
-	27. Manner of De		28a. Dete of Inju	ry 28b	Time of 26	-			how injury occur		
funer stion	1 ☑Neturel 2 ☐ Accident	5 Pending Investigation	(Month, De	y Year)	Injury M		Yes 2 No				
Medical Certification:	3 ☐ Suicide	6 Could not b	288. Place of in	jury - At home,	ferm, street, fectory,	office	4	28f. Location (S	Street and Numb	er or Rurel Rou	te Number,
d in	A D Homicia		building, et	c. (Specify)				City of Tol	WII, SIAIE/		
y fille	29e. Certifier	Cortifying Ph	yelcian: To the best	of my knowled	e, death occurred e	t the ti	me, date end plece, a	and due to the	cause(s) and m	anner as stated	
edicai	(Check only one)	2  Medical Exam	end manner st	t examinetion e eted.	ind/or investigation,	In my o	opinion, deeth occurre	ed et the time,	dete and place,	end due to the d	euse(s)
1	29b. Signeture er	nd title of certifier	, ,	,			se number		29d. Date signe		
V		1. 14	c Con	1/	no	03	38762		Octok	zer 16,	2000
Mil	30. Neme and ad	dress of person who	completed ceuse of o	deeth (Item 23e	) (Type, Print)	11/-	1,4				
10	Dr. Sha	ron McCorn	nack, 5411	Old Fr	ederick R	d.,	Suite 18,	Balti	more, M	d. 21229	)
State	31. Dete filed (Me	11.50		rer's Signeture							

State Registrar 31. Dete filed (Month, Dey, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32690 Certificate of Death Amended Items 37,8 per FHG 788 10/17/2000 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** 6.15 PM H Lard 0 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Moriner Health Bornie Glen Burne 21en Anne Arundel Hours Min. 8. Date of Birth 6-6-14 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10 M 2□ F 218-10-858 86 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or items 23a or 28a-f ahor 1 TYRS X NO NO Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 S. 2nd Avenue 21061 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? filed within 72 hours efter Hyglene. Wher then "neturel", or ite 1XXNever Merried 2 ☐ Married aitimore. Marviand 21215-0020 1 Yes XXNo Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lathe Operator Lumber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any Injury or other traumatic avarm Botes. Be John Ford Mary Fogerty 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret M. Franke - sister 5 S. 2nd Avenue, Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1 Nurial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Glen Haven Cemetery 10/13 Glen Burnie, MD 21. Signature of Funeral Service Licens 22. Name end Address of Facility FINK FUNERAL HOME, PA 426 Crain Hwy., SW, Glen Burnie, MD 21061 Kelly Gregory Fink 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailurit. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** THEROSCIEROTIC CARDIOVASCULAR /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner The lew requires that the death certificate be executed bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical physics the t Due to (or as e consequence of): . USB P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, p 50 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 Yes 2 No of Vitai or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manper of Death 28b. Time of 28c. Injury at Work? After Natural 5 Pending investigation Division 24 hours after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier &C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. within 2 To the

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Wells

DCT

Name and address of person who completed cause of death (Item 23e) (Type, Print)

ASNEEM ALHANI. 722

2000▶

**DHMH 16 Rev 6/95** 

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32. Registrar's signature

ARHANI

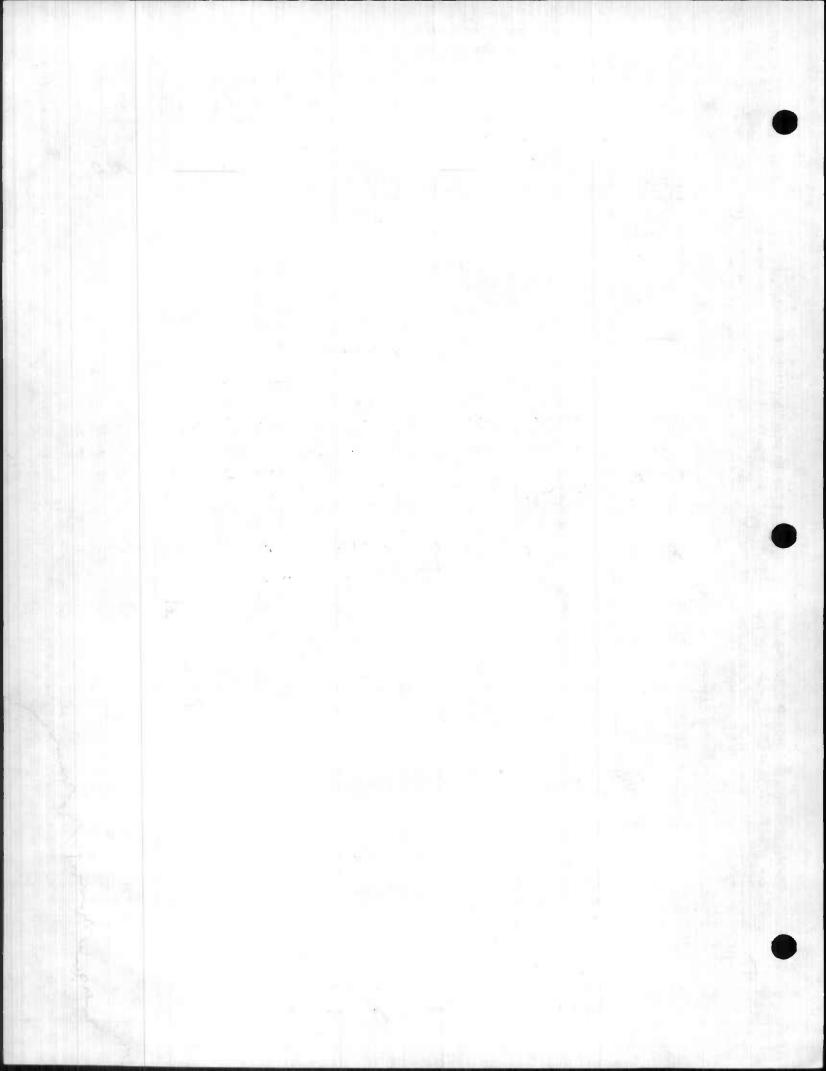
29c. License number

PARK

28595

29d. Date signed (Month, Day, Year)

HEIGHTS AVE

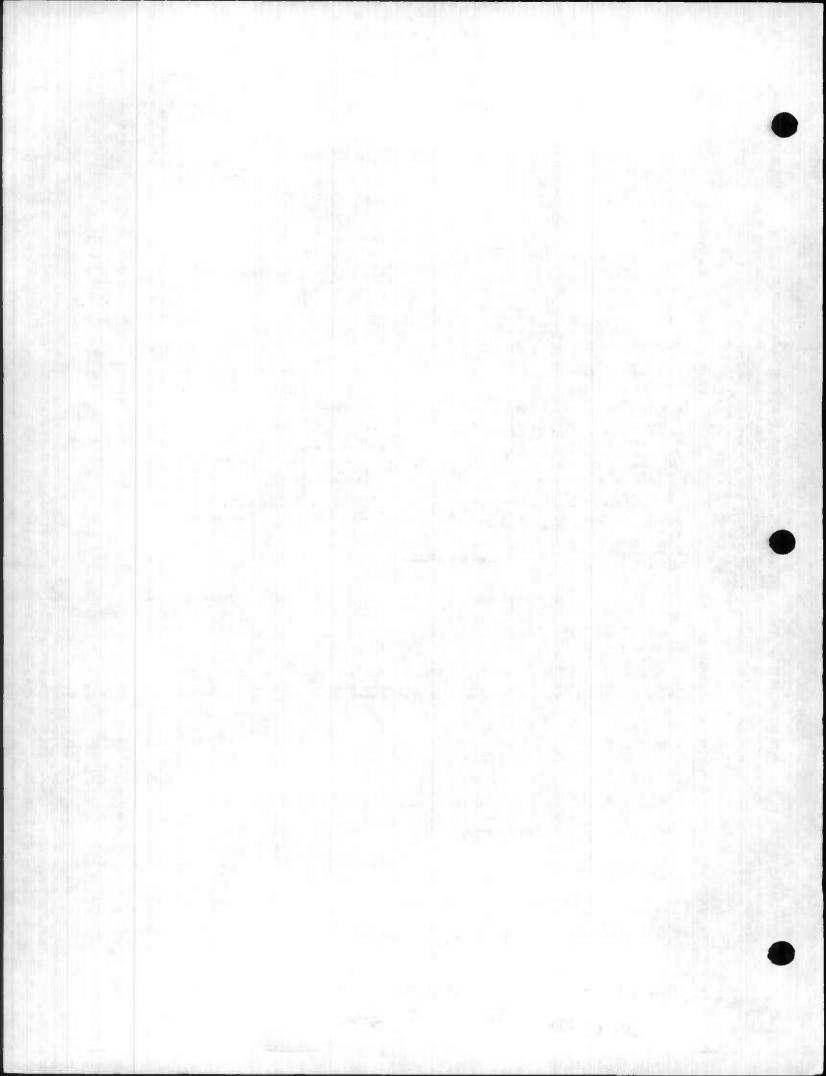


an	Decedent's Neme (/			- T				2. Dete of E Month	Reg. No. Deeth	Yeer	3. Time of Death
	Eliza			agne				Octobe	er 6, 20	000	7:15 a.m
40	Facility Neme (If no	ot institution, give a Maris	e street end number,	)			46. City, Town, TOW:	or Location of Dec			ore Co.
5.	Social Security Num	nber 6. S		ge (In yrs. i		if Under 1 Yeer	If Under 24 I				
_	66-12-306	3	□M 2Å)F	8	1 Yrs.	Months Deys	Hours N	Sept.	21,1919	Penns	ylvania
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4	aryland	N/	A	В	altimore	e					₩ Yes 2□1
-	e. Streel and Number					10f. Zip Code			10g. Citizen of \	What Count	try?
	5404	Seward /	Avenue				21206			ted St	
	Maritel Status		12. Wes Decedent Armed Forces	?	S. 13. We	s Decedent of I es, specify Cub	lispanic Origin? en, Mexicen, Pu	(Specify Yes or I uerto Ricen, etc.)	No- 14. Rad Blad	ce · America ck, White, e	
	1 ☐ Never Married 3 🕅 Widowed 4 [		1 Yes 2 1 If Yes, Give Yeer or Detes:		10	Yes 2X No	Specify:		Specify	y: Wt	nite
		5. Decedent's Ed			16e. Deceden	nt's Usuei Occup ad of work done	nation	working	16b. Kind of B	usiness/Ind	lustry
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7	. Father's Neme (Fir	rst. Middle Last)				Homemak		Name (First, Midd	UWI le, Meiden Sumen	n Home	6
	Michael	Robin					Mary				
19	e. Informent's Nemo		Type, Print)		19b. Meiling	Address (Street			nber, City or Town,	, Stete, Zip	Code)
1	. Raymond	d G. Gag	ne, Jr. /	Son		E. Jopp	a Road	Baltim	cre, Mar	yland	21234
20	e. Method of Dispos		Removel from Stete	0	lece of Dispositi em <i>etery, cre</i> met	ion (Neme of tory or other ple	ce)	Dete	20c. Location		
	4 Donetion 5	Other (Specify	y)	St.	. Stanis			10/9/20	000 Bal	timor	e, Md.
21	I. Signeture of Funer	rel Service Licen	Intra idei		iahh	lame end Addre			305 Harf		
21	3a. Pert1. Enter the shock, or heert le	diagona or com	Carrayy/						Baltimor	e, MD	21214 Approximete
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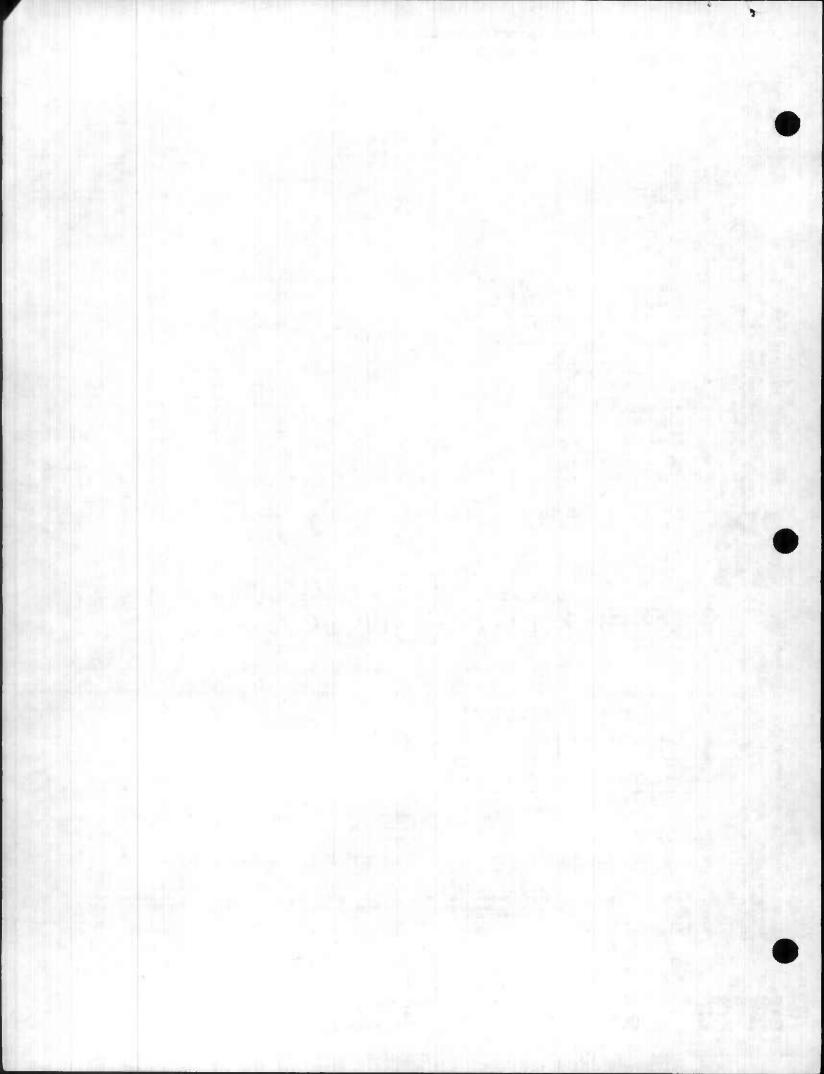
ELIZABETH GAGNE



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			olate of war year	Certific	cate of L	Death	Reg	ı. No.			
	. 4.10	1. Decedent's Name (First, Middle, Las	1)				2. Date of Death Month		Year	3. Time of Death	
Ġ.	Physician /Medical	SHAR	N	GREE	NE		PLTOBE		2000	1:509	1
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	D	Usual Residence of Decedent  10a. Stata 10b. County	10c. Ci	ity, Town or Location	1				100	d. Inside City Limits	5
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	ith with the Maryda 23a or 28a-f sho ust be notified at ral Director	10e. Street and Number 3285 Haverhill 1	Rowe	10	f. Zip Code	0044	100	g. Citizen of W	hat Countr	y?	
	South ma 23 mas mera	11. Marital Status	12. Was Decedent Ever in U	J,S. 13. Was D		Ispanic Origin? (Spe In, Mexican, Puerto I	cify Yes or No-	14. Race	- America		
21215-0020	at, or the Examinat by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give- Year or Dates:		specify Cuba	Specify:	Rican, etc.)	Specify:	, White, et ${ m B1}$	ack	
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and	and be for the first of the fir	Richard Harris							,		
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×	and 2 27 is 27 is r tres	Danielle D. Greene	e/daughter	3285 Ha	verhi1	1 Rowe La	wrencevi	11e. G	A 300	44	
more	of He Item	20a. Method of Disposition	20b.	Place of Disposition cemetery, crematory	(Name of or other place	·e)	Date 2	Oc. Location - (	City or Tow	n, State	
Ĕ	Pag ment ury o	1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Memoval from State	tro Crema			/16/00	Balti		MD	
Balt	Departiment in post in particular in post in particular in	21. Signature of Funeral Service Licen	samulal .	22. Nan Cren 299	ne and Address nation Freder	ss of Facility Society of rick Road	f Maryla	nd, In	C.	0	
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_	Pital C	29a, Certifier SC Certifying Ph	ysician: To the best of my kn	nwledge death occu	great at the tin	ne date and place	and due to the car	isa(s) and mai	nnar ac eta	ted	
	To the Hospital or Attending Ph within 24 hours after death. To the Fureral Director: After th completely filled in by the funeral Medical Certification: 7		iner: On the basis of examinand mannar stated.								
	Vithin To the complete	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed	(Month, D	ay, Year)	
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	0-		ombleted cause of death (Ite	m 23a) (Type, Print)	. (		. 4				
	n	2000 W. Bai	timeres.	freet, B	saltr	morey	MD 21	225			
	State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature Z	-	- 1.					
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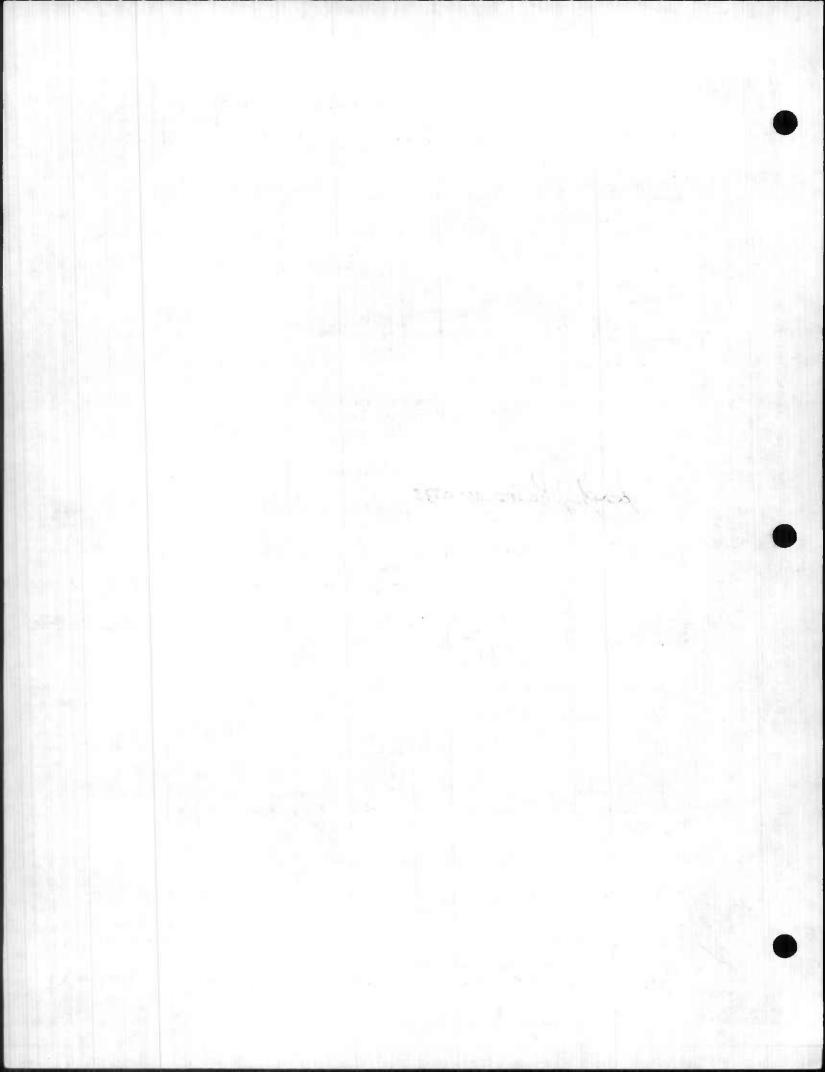
State of Maryland / Department of Health and Mental Hygiene 32693 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Year **Physician** FREDERICK 10:27 PM OCTOBER 13 WILLIAM GIANFORTE 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death **Examiner** HOSP ITAL KANDALLSTOUN LENTER BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) May 3, 1931 9. Birthplace (State or Foreign Country) New York 5. Social Sacurity Number 6. Sex **Funeral** Months 13M 20F 69 Director 214-26-4834 Usual Residence of Dacedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No Director Baltimore 28a-f Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or U.S.A. 21133 3726 Collier Road Funeral 14. Race - Amarican Indian, Black, Whita, etc. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Maritel Status 1 Navar Marriad 2 Married 1 Yas 2 No If Yas, Giva Yaar or Datas: b 21215-0020 1 ☐ Yes 2 ☑ No Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Crest Automatic Hygiene. Elamentary/Secondary (0-12) Collega (1-4or 5+) Self-employed 8 Transmissions Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H lant: If from 27 is marked off Charles Joseph Gianforte, Sr. Anna Mae Metzger 19a. Informant's Name/Ralationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucille Gianforte (Wife) 3726 G. Collier Road; Randallstown, MD 21133 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removel from Stete Lake View Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 10/17/00 Sykesville, Maryland 22. Name and Address of Facility Oring Byers Funeral Directors, Inc Kellnor MO 0333 8728 Liberty Road; Randallstown, MD 21133 he of base, & complidations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician Immediata Causa (Final diseasa or condition rasulting in death) /Medical 45 MINUTES VENTRIWLAR FIBRILLATION Examiner Dua to (or as a consequence of): Examiner ACUTE MYDIANDIAN INFARCTION 1 HOUR The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immediata causa. Enter Undarlying Cause (Disaase or injury that initiated avents rasulting in death) Last HYPERTENSIVE GARDIOUASCULAR DISERSE Box 68760. Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the cause of death? P.O. pege 2 should be detact 1 Yes 2 No 3 Probably ∮SUnknown DIABETES MELLITUS p Records. 24b. Wara autopsy tindings available prior to complation of cause of death? Be Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 ∏Yas 2 ∏ No this certificate Division of Vital Attending Physician: funerel director. 25. Was casa referred to medical 26. Place of Death (Check only one) axaminar? Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 2500A Certification: To 1 Yas 2 No 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? After 1 Natural 5 Pending invastigation within 24 hours after death.

To the Funeral Director: Al
completely filled in by the fu 1 Yes 2 No 2 Accidant 6 ☐ Could not be datarmined 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 4 ☐ Homicida 6 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar statad. 29a. Cartifier Medical (Check only one) ŧ, 29b. Signetura end titla of certified 29c. License number 29d. Data signed (Month, Day, Year) 0 D470BER 13 2000 30. Nama and address of person who complated cause of death (Item 23a) (Type, Print) OLD COURT ROAD RANDAUSTOWN MD 2133 MNE. MP 5401

DHMH 16 Rev 6/95

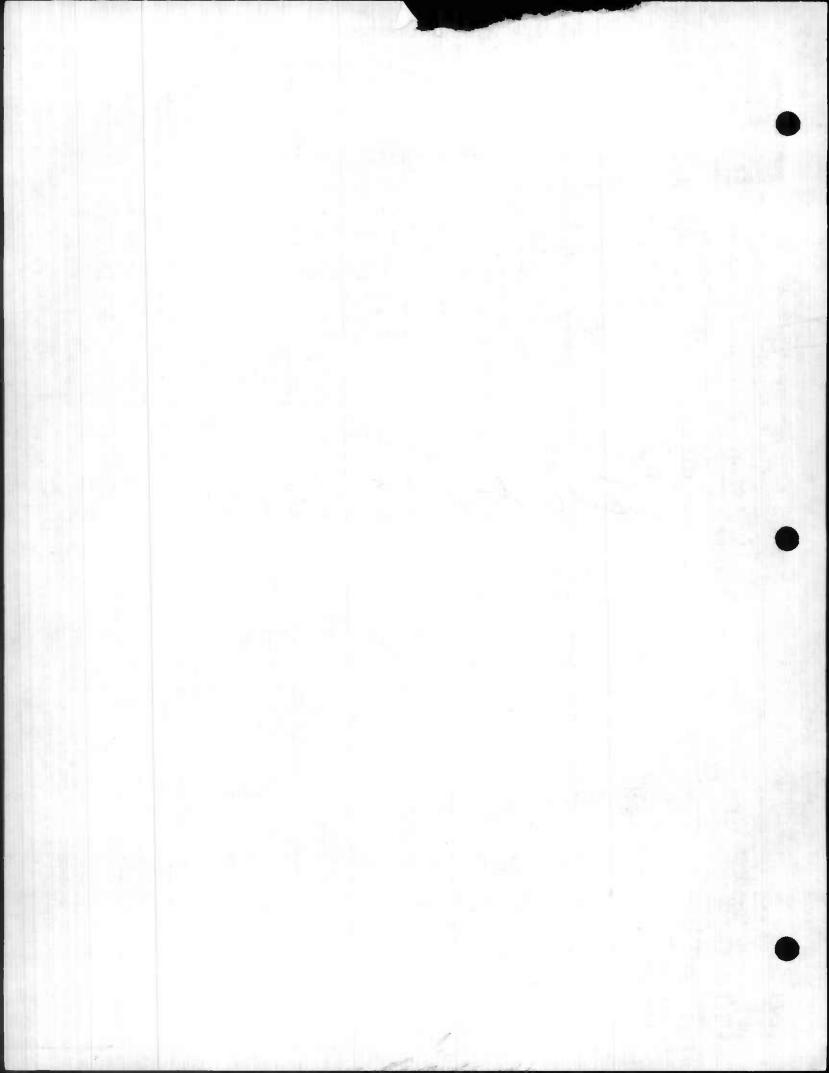
State Registrar 31. Data filed (Month, Day, Year)

32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene 00 32694

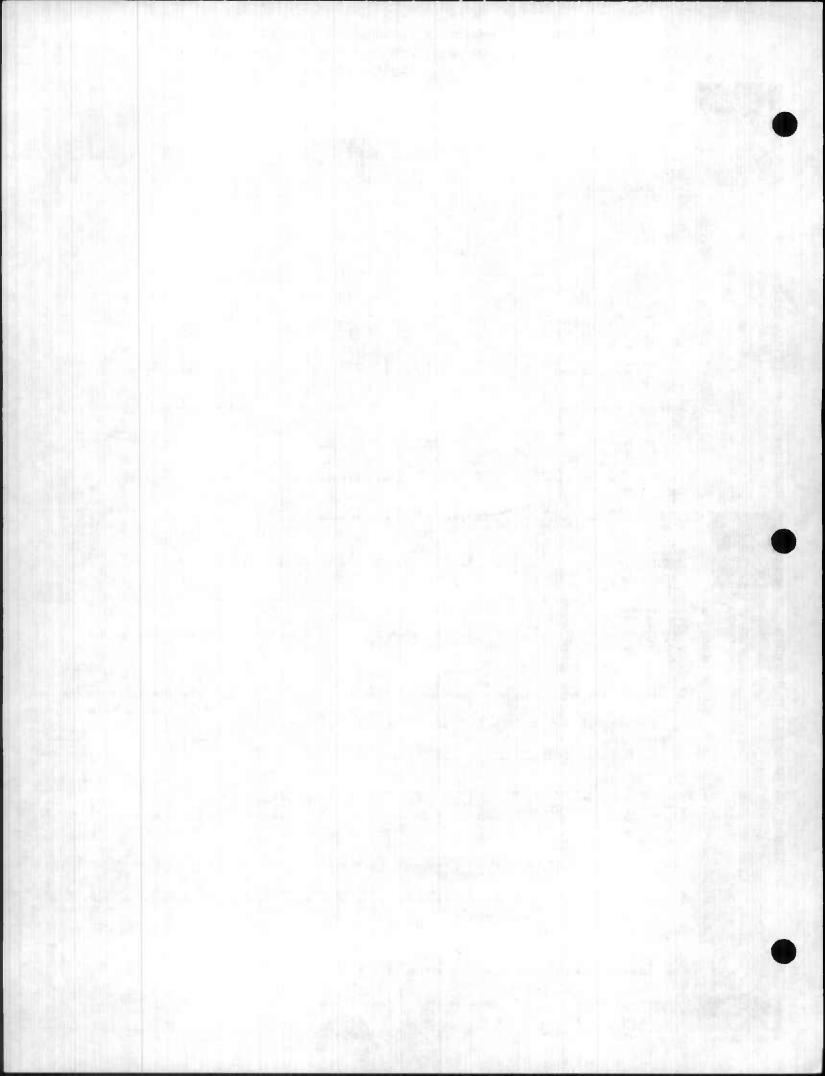
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Funeral Director	5. Social Security Number 6. S 219 38 4693		(In yrs. last birtl	rs. Months		Hours	Min.	8. Date of Bird (Month, Da 2 / 2 / 4	Y Year)	9. Birthp Cour	place (State or Foreignty) MD.
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free death v freeze 23 per ment	11. Merital Status	12. Wes Decedent E	ver in U.S.	13 Was Dec	edent of H	lispanic Ori	ioin? /Soc	acify Yes or No	14.	Race - Americ	an Indian
P P P	The state of the s	Armed Forces? 1#☐ Yes 2 ☐ No		If Yes, sp	ecity Cubi	an, Mexicar	, Puerto	ecify Yes or No Rican, etc.)		Black, White,	
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SEE	19a. Informant's Name/Reletionship (	Type, Print)	196.	Meiling Addre	ss (Street	and Numbe	er or Rura	al Route Numb	er, City or T	own, Stata, Zic	(Code)
	JESSIE MAE PAR	RKER	2	503 LA	URE'	TTA A	AVE.	BALTO	O. MI	212	23
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Physician: this certific ral director, TO Be	27. Manner of Death							28d. Describe			γ/
or death.  Story the funer  Iffication	1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) In	jury	28c. Injur Wor	k? Yes 2□		200.000.00	now anjury o	oouoo	
death.	2 Accident investigation 3 Suicide 6 Could not b					165 21					
a bleedoath.  I Director: After the od in by the funera  Certification:	4 Homicide datarmined	28e. Place of Injur building, atc.	y - At homa, fan (Specify)	m, street, facto	ry, office			28f. Location ( City or To		lumber or Rure	al Route Number,
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0											
To the Propriet or Amendment Propriet of the Purper all pre-closes After the completely filled in by the funeral Medical Certification:	(Check only 2 Medical Exam	ysician: To the best of niner: On tha basis of a	examination end	death occurre /or investigation	d et the tin	na, data an pinion, dea	d place, a	and dua to tha ed at tha time,	causa(s) an data end pla	d manner as s ace, and dua l	tated. the ceusa(s)
Med Med	one)	end menner stet	ed.		9c. Licens						
0 × 0 0	29b. Signature and title of certifier			2	C. LICENS	e number	,		250. D818 \$	signed (Month,	Day, 1947)
	I full to feel	7 08			PI	4666			October	- 12.	2000
	30. Name end eddress of person who		eth (Item 23a) (T	Type, Print)					- 0,170	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,
		TIMORE VA		orth Gr	100	Stret	-	BALTIN	16	212	201
Curr	31. Date filed (Month, Dey, Year)	32. Registrar		ALL AL	ecitte .	101		5/101 (70)	- NE M	, 212	1
State Registrar	OOT 1 C c	000	and a	6	1						



State of Maryland / Department of Health and Mental Hygiene 00 32695

				Certi	ficate of	Death		Reg. N	lo.		
1,1,1,1	1. Decedant's Name (First, Middle, La	est)					2. Dete of Month		еу	Year 3	. Tima of Death
Physician /Medical	JANET	М.		H	ARGETT		OCTOB				2:15 PM
Examiner	4e Facility Neme (If not institution, gir	ve street and number)				4b. City, Town,	or Location of De	ath 4	c. County	of Deeth	
757	7104 AVESBURY LA	NE				FERNDA			AN	NE ARU	NDEL
Funeral		Sex 7. Ag 1 M 2 ☑ F	e (In yrs. last bin		If Under 1 Year Months Days			Birth Dey, Yea	r)	9. Birthplace Country)	e (State or Foreign
Director	215-28-9027 Usuel Residence of Decedent		69	115.			AUG.	24,	1931	NEW Y	ORK
ytand M M	10a. State 10b. County		10c. City, Town	or Local	tion					10d.	Inside City Limits
2 24 6	MARYLAND ANNE	ADIMEDET		T ENT	DUDNIE						1 ☐ Yes 2 No
or 28s-f s be notified	10e. Street and Number	ARUNDEL		LEN	BURNIE 10f. Zip Code			10g. C	itizen of V	Whet Country?	)
	7469 FURNACE BRAI	NCH ROAD,	APT. C		210	060			U.S.	Α.	
her death rither death increase 23 increase 24 increase 25 increas	11. Merital Status	12. Was Decedent Armed Forces?	Ever in U,S.	13. Wa	s Decedent of	Hispanic Origin	? (Specify Yes or uerto Rican, etc.)	No-		e - American I	ndien,
D20	1 ☐ Never Merried 2 ☐ Married 3 🖔 Widowed 4 ☐ Divorced	1 Yes 2X11 If Yes, Give Year or Dates:			Yes 2 No		derto Filoan, etc.,			WHITE	
d February			16a	Decedan	nt's Usuel Occu	netion		16b.	Kind of Bu	ualness/Indust	rv .
I 21215-0 ad within 72 ho yglene. we than 'natur 4, the Medical. Completed	(Specify only highest gr	rade completed)		(Give kin	of work done NOT use retin	during most of	working				
212 212 1 with 1 lines 1 lines 1 lines 2 lines 2 lines 2 lines 3 lines	Elementery/Secondary (0-12)	Collega (1-4or 5	P+)	OME	CARE PI	ROVIDER		НЕ	EALTH	CARE	
De file dothe event,		1)				18. Mothar's	Name (First, Midd	ile, Meide	n Sumer	ne)	EXX.5
/lar		Α.		JC	NES	HAZEI			GI	LBERT	
Maryland 21215-0020 d 2 should be filed within 72 hours at th and Mental Hygiene. 7 is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by I	19a. Informant's Name/Relationship	(Type, Print)	19b	Mailing .	Address (Stree	t end Number o	r Rurel Route Nur	nber, City	or Town,	Stata, Zip Co.	de)
- 5 TO 12	SUSAN SMITH (DA	AUGHTER)	71	04 A	VESBUR'	Y LANE,	FERNDALI	E, MI	21	061	
Baltimore semil. Pages 1. aparlment of He mportant: If Hen my Injury or oth mos.	20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐			y, cremat	tory or other pl	ece) IAL PARE	10/17/2	000		City or Town,	
District of the last of the la	4 Donetion 5 Other (Special Signature of Funere Service Like	•					SINGLETON				
m katta	1 SI CL						S.W., GI				
	23a. Part1. Enter the disease, or comshock, or heert failure. List only	nplications that caused	the death. Do r							Ao	proximete
Physician	shock, or heert failure. List only	one cause on each li	ne.								arval Between nset and Deeth
/Medical	Immedieta Cause (Finel diseese or condition		Chr.		c Q	1/200	. n. n.	-	ase.		
Examiner	resulting in deeth)	8.	Due to (or es a			7 7 0 100	100	Jee	350		
P = 2											
8760, sate be executed thysician and the burial-transit	Sequentially list conditions, if any, leeding to immediate	D	Due to (or es e	onseque	nce of):						
. BOX 68760, death certificate be execut e attending physician and ad for use as the burial-transition.		6									
68760, ficate be expression as the buria	that initieted events resulting in death) Last		Due to (or as a	onseque	nce of):						
X 6.		d					10000				
P.O. BOX hat the death cer d by the attendin letached for use										1	
the de parties de la ched	Pert II. Other significant conditions	contributing to death b	uf not resulting in	the unde	erlying cause g	iven in Part I.		3.00			e cause of death?
2 2 00	Dury Cypice	12455				VA		Yes	2∐ No	3 Probab	ly 4 ☐ Unknowr
Vital Records, P.O. siden: The law requires that the de certificate has been signed by the irector, page 2 should be detached to be completed by Physics	7							as an au			autopsy findings
Short short							_ pe	erformed'			ble prior to lation of cause http://
Vital Rec vicien: The law certificate has trector, page 2 s							1	Yes	2 00 No	1 🗆 Y	M
tal	25. Was case raferred to medical					26 Pleas of	Death (Check on		2 450 40	Day	12/4-1
Of Vita Physician: this certific ral director,	exeminer?	Hospital:	ent 2 ER/Ou	tnatient	3 DOA	ther:	ng Home 5□R		6 <b>9</b> (Oth	ner (Specify)	Toma !
0 4 44		28e. Dete of Inju (Month, Da		lime of	28c. Inj		28d. Descri				10.
Attending Ir death.  Sector: After by the fune-	PS Naturel 5 Pending Investigation		y rear)	njury		Yes 2□No	YELD. Y				
Division for Attending after death. Director: After d in by the fune	3 Suicide 6 Could not be datarmined	4   286. Piece of inj	ury - At home, fa c. (Spacify)	rm, stree	t, factory, office	•		n (Street Town, St		ber or Aural A	oute Number,
Division (  bal or Attending P  sa ther death.  in Director: After t ed in by the funera Certification:	Tollicida	building, at	c. (Spacity)				Ony or	, own, on	310)		
ospital hours a uneral filled bity filled	29a. Certifier Certifying Pl	hysician: To the best									
Divi	one)	end manner sto		- HIVES			Joseph Strate till till	, .			
To the comple	29b. Signature and title of certifier	x 1 6	P		29c. Licer	nse number		29d. [	pate signe	ed (Month, Day	r, Year)
IVO	elan	shope,	1	-	D.	215	)	10c	toper	16,2	000
1/2	30. Name end address of person who	completed cause of d	leath (Item 23a)	Type, Pri	int)	. 1)	) (	(20	Ω.	1.1 -	110/1
9	31. Date filed (Month, Day, Year)	Selver 20 Paris	ar's Signature	600	2000	you A	Bound?	UK	אוכוי	w who	4001
State	31. Date med (Month, Day, Tear)	JZ. Hegistr	ar s Signature								

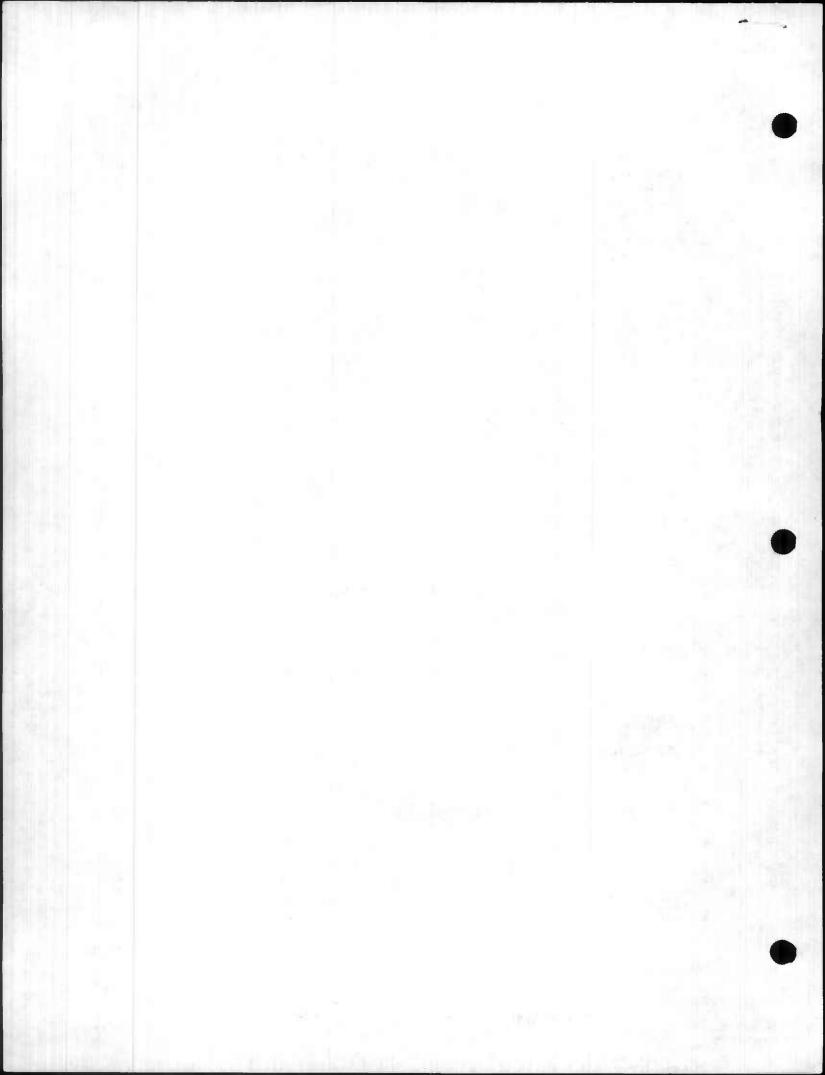
ORIGINAL



State of Maryland / Department of Health and Mental Hygiene

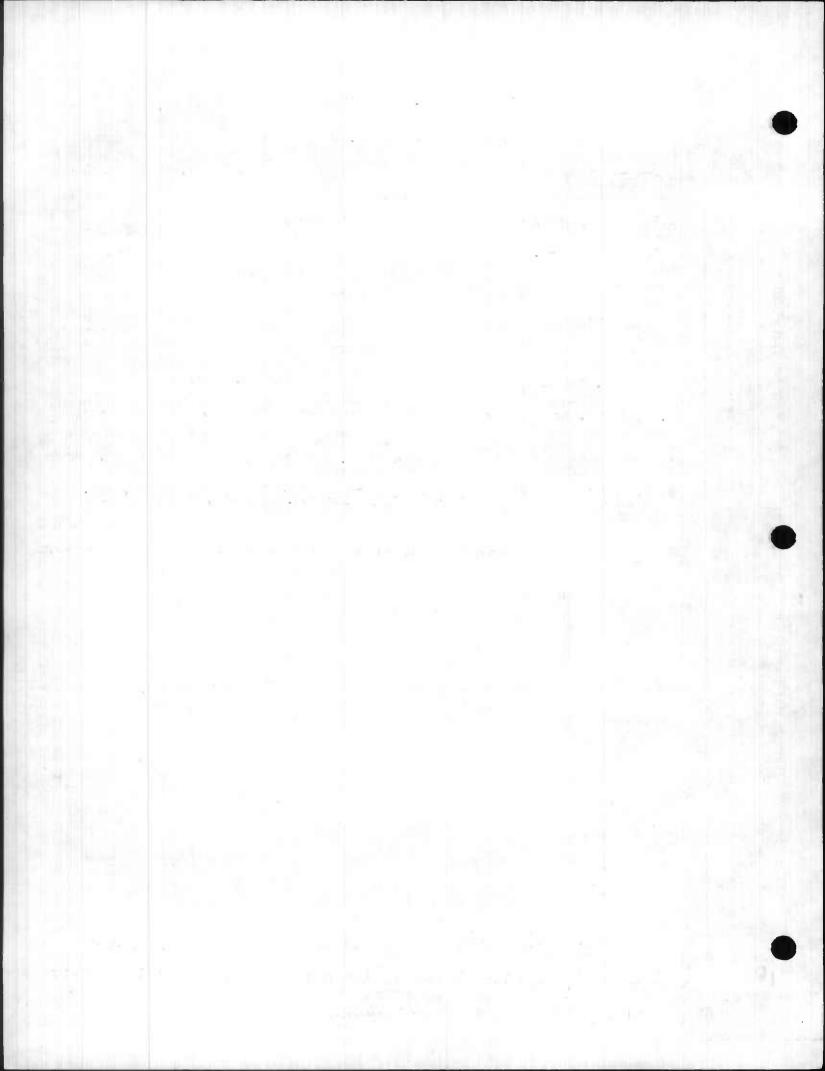
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3	6	0	7	6

	1. 0	#23a perPl			UUU EW		001	inica	10 01	Death	2. Date of De		y	3. Time of Death
Physician /Medical		CARROLI	L HAT	RTMAN	1						SEPTEMBE	R 22,	7000	3:55 pm
Examiner	4.5	Facility Name (I	f not institution	n, give stre	et and numb	er)			- 1	4b. City, Town, or			ty of Death	
		ARBOR HO				A (1	f 4 & 2 ab - 3	H I Ind	ar 1 Yaar	BALTIMOR			N/A	(0)
Funeral Director	21	Social Security N	375	6. Sex 123 M	20 F	59	last birthday) Yrs.	Months		Hours Min.	8. Date of Bi (Month, Da Feb. 6	1941	9. Birthple Counti Md.	ace (Stata or Foraign ry)
B 10		ual Residence of a. State	10b. County	,		10c. Cit	y, Town or Loc	ation	-				10	d. Inside City Limits
fled a		Md.	Bal	timo	re	1	Edgeme	re						1 □ Yes 2√ No
be notified Director	100	. Street and Nur	mber		- 1			10f. Z	ip Code	Partie 10		10g. Citizen of	What Count	ry?
		2111 L	incol	n Av	e.			2	1219	9		USA		
Examiner must	6	Marital Status  1 Never Marri 3 Widowed		ried	Was Deceda Armed Force 1 ☐ Yes 2] If Yes, Give Year or Data	s? ☑ No			edent of Hecify Cubi	tispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yas or No o Rican, atc.)	Bio	ica - America ack, Whita, e ify: Whit	tc.
ated ated		(Spec	15. Deceder	nt's Education	on mplated)		16a. Deced	ent's Us	uat Occup	ation during most of wo	rkina	16b. Kind of I		
Agreement and the Medical of the Medical of Completed	-	Elementery/Seco	ndery (0-12)	Ť	College (1-4	or 5+)	life. C	O NOT	use retired	d)				re City
CO PA	17	9 yr		I act)			Su	per	vis	18. Mother's Nar	ne (First Middle	Automo		
c even	2		liam		artma	n				Anna I		s, marden Suma	inter	
T SEE	-	e. Informant's Na	ame/Relations	ship (Type,	Print)		19b. Meilin	g Addre	ss (Street	and Number or Ru	ural Route Numb	ber, City or Town	n, State, Zip (	Code)
101	N	Nancy H	artma	n	wif	e	2111	Li	ncol	ln Ave.	Edgeme	ere Md	. 212	19
ant: If Item ary or other	206	a. Method of Disp 1 XBurial 2 ( 4 Donation	Cremation		oval from Sta		Ptace of Disposementery, crem cred H	afory of	other play	Jesus	Sept.20		- City or Tow dalk	vn, State
maporta any inj	21.	Signature of Fu	Sus 1	Licensee	2	7	Co 71	Name nne 10	and Address 11y Soll	Funera Lers Po	l Home int Rd	Of Du	ndalk 2	
ing physicien and see as the bunal-transit see as Medical Examiner	Se if a car	mediete Cause ( sease or condition sulting in deeth)  quentially list control any, leading to im use. Enter Unda use (Disease or sulting in death) t	nditions, imediate urlying injury	a b c	METAS	Due to (c	FCTAL AD or as a consequence of a consequ	ADE	): : NOCA ):	MA Remewa				2 YEARS
for use e														
igned by the be datached by Physic	Par	RENAL 1	NSUPF			n but not res	ulting in the un	derlying	cause giv	ven in Part I.		tobacco use c Yes 2□No	1	the cause of death ably 4 Unknow
been s should		GASTROIN	UTESTINA	AL BL	EEDING							s an autopsy formed?	ava	re autopsy findings ilable prior to appletion of cause leath?
page 2											10	Yes 2 No	10	Yes 2€No
director, pay		Wes case references	red to medica	ı						26. Plece of De	eth (Check only	one)		
F G	2	1□ Yes 2☑		Hosp	1 M Inp		ER/Outpatient	3 🗆 (	JUA		lome 5 ☐ Res			)
After	27.	Menner of Death  Netural  Accident	5 Pendir investi	ng igation	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	М	28c. Injui Wor 1 🗆	ry et rk? I Yas 2 □ No	28d. Describe	how injury occi	urred	
		3 Suicide 4 Homicide	6 Could determ	nined	building,	etc. (Specil					City or To	(Street and Nun own, State)		
us aref deam. ral Director: After t lled in by the funers Certification:	)	a. Certifier	1 Certifyir	ng Physicia Examiner:	on the basis and manner	s of examina	wledge, death tion and/or inv	occurre	d at the tir on, in my d	me, date end place opinion, death occu	e, and due to the urred at the time	cause(s) and n , date and place	manner es sta e, and due to	ated. the cause(s)
he Funeral Direct pletely filled in by	29	(Check only one)	2   Medical											
within 24 hours are located to the Funeral Director: completely filled in by the Medical Certificate	29			1				2	9c. Licens	sa number		29d. Date sign	ned (Month, E	Day, Year)
Within 24 hours areno To the Funeral Direct completely filled in by Medical Certifi	296	one)	The sportified	p	8	MD , MD	n 23e) (Tune I			428		29d. Date sign		



State of Maryland / Department of Health and Mental Hygiene 00 32697

ian						nilicate		200011			Reg. No.		
cal _	Decedent's Nama	a (First, Middla,	(Gla	dys	C.	Но	gue			Data of De Month Octobe	Day	Yeer 00	3. Time of Deeth 8:35 P
	4e Facility Nama (If	f not institution,	giva street and no	ımber)			4	b. City, To	wn, or Local	tion of Death	4c. County	of Death	
	Genesis	s Herita	age Meri	dian El	dercare	e Ctr.		Du	ndalk		Ва	ltimo	ore
	5. Social Security No	umber 6	S. Sex	7. Age (In yrs	. last birthday)	If Under	1 Year Days	If Under		Data of Birt	th v. Year)	9. Birthp	laca (Stata or Fora
	213-07-	7988	1□M 2€3F	93	Yrs.	MONTO	Days	110010		July 2	y. Year) 24, 1907	Mai	ryland
-	Usual Rasidence of			140- 0	* T								
	10a. Stata	10b. County		10c. G	ity, Town or Lo	cation						1	0d. tnsida City Limi
Director	Maryland	В	altimore				Edge	emere	1				1 ☐ Yes 2 🛣 N
2	10a. Street and Num	nber				10f. Zip	Code				10g. Citizen of V	/hat Coun	itry?
Funeral	3010 R:	itchie :	Ave.					2121	.9		United	Stat	ces
5	11. Maritel Status		12. Was Dec	edent Ever in U	J,S. 13. \	Was Decede	ent of Hi	spanic Ori	gin? (Specif	y Yas or No an, etc.)	- 14. Race	e - Amaric k, Whita.	
	1 Never Marrie	ed 2☐ Marrie		2 No		1 Yes 2			, 1 00110 1110	ALT, 010.7			
	3 Widowed	4 Divorced	Year or I	Dates:		10 163 2	LANTO	ореспу.			Specity	W	nite
	(Snec	15. Decedent's	Education grade completed,		16a. Deced	dent's Usual	t Occupa	ation	t of working		16b. Kind of Bu		
	Elementary/Secon			1-4or 5+)	life. L	DO NOT use	e retired,	)	· cr working		Baltim		-
	12 Year	S			S	ecreta	ary				School	S	Clerical
	17. Father's Nama (	First, Middla, Le	est)								Maiden Sumam	a)	
	Joseph	A. Cus	ter					Ma	abel E	. Krai	ık		
	19a. Informant's Na				19b. Mailin	ng Address	(Street a	and Numbe	er or Rural F	Routa Numb	er, City or Town,	~	
	Mr. Wesl	ey C. H	ogue (S	on)	110	Victo	ory	Lane	Bel	Air,	Marylan	23	1:014
1	20a. Mathod of Disp	position		20b.	Place of Dispo	sition (Nam	a of	-1		Date	20c. Location -	City or To	wn, Stata
	1 Burial 2	Cremation 3	Removat from	Stata	cematery, cren				0/10/	2000	Polti	mara	, Marylan
+	21. Signature of Fur		city) Enton	bment	Morela	nd Men				2000	Balti	шоте	, Marytan
		Service Ci	-W								5 D	1. T.	2 2
	ONL	Plane	27/10	essey	1	7922 W	lise	Ave.	Dung	dalk,	E Dundal Marylan	21	1222
	23a. Part1. Enter the shock, or hear	ha diseasa, or contra distor	omplications that	caused the day	Do not ent	er the mode	of dying	g, such as	cardiac or r	espiratory a	rrast,		Approximata Intarval Between
													Onset and Death
	Immedieta Cause (I diseasa or condition	Finat n	CEY	core	Vasa	بعاد	1	AC	cide	=nt			Imont
- 1	resulting in deeth)		a	Due to (	or es a conseq	quence of):				1 12		1	
- Name	Sequentially list con	nditions,	D	Due to (	or as a conseq	quence of):				- 4			
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2	cause. Enter Under	rlying											
=	Sequentially list con if any, leading to improve cause. Enter Under Cause (Disease or it that initiated events).		C	Due to (	or as a conseq	uence of):							
Medic	cause. Enter Under Cause (Disease or i that initiated events resulting in death) L		С	Due to (	or as a conseq	uence of):							
2	THREE MINISTER GARLIES		d	Due to (	or as a conseq	uence of):							
2	resulting in death) L	ast	d				use nive	on in Part I		23h Did	Inhacco usa cor	atribute to	) the cause of deat
2	THREE MINISTER GARLIES	ast	ds contributing to c				use give	on in Part I					o the cause of deal
rnysicianym	resulting in death) L	ast	ds contributing to a				tuse give	en in Part I			lobecco use cor Yes 2⊠No		o the cause of deat
- C	resulting in death) L	ast	ds contributing to d				tuse give	en in Part I		10	Yes 2 No	3 □ Prol	bably 4 Unknown
ey ruyalcidiem	resulting in death) L	ast	d				ause give	en in Part I		1 🗆 24a. Was		3 ☐ Prof	are autopsy finding allable prior to mpletion of cause
-	resulting in death) L	ast	ds contributing to o				use give	en in Part I		1 🗆 24a. Was	Yes 2 No	3 ☐ Prof	bably 4 Unknown
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Completed by Physician M	Pert II. Other algnific	ast	ds contributing to d				ause give			1 🗆 24a. Was perfo	Yes 2 No an autopsy med?  Yas 2 No	3 Prof	are autopsy finding allable prior to mpletion of cause death?
se completed by Physician/M	resulting in death) L	icant conditions	Hospital-	leath but not re-		nderlying ca	Onthe	26. Place	e of Death (	1 24a. Was perfo	Yes 2 No an autopsy med?  Yas 2 No	3 Prof	are autopsy finding allable prior to mpletion of cause daath?
o complete by rilysication	Pert II. Other eignifications 25. Was casa referraxaminer?  1 \( \text{Yas} \) 25. Manner of Death	icant conditions	Hospital: 1 U	leath but not re-	sulting in the un	nderlying ca	A Other	26. Place	of Death (	24a. Was perfo	Yes 2 No an autopsy mmed?  Yas 2 No ona)	3 Prof	are autopsy finding allable prior to mpletion of cause daath?
to be completed by rhysicianym	Pert II. Other significations of the second	icant conditions red to medicat	Hospital: 1 □ 28e. Date (Mor	leath but not re-	sulting in the u	nderlying ca	A Other	26. Place	o of Death (c)	24a. Was perfo	Yes 2 No an autopsymmed?  Yas 2 No ona)	3 Prof	are autopsy finding allable prior to mpletion of cause daath?
	25. Was case referred axaminer?  1 Yes 25. 1 Yes 25. 1 Yes 27. Manner of Death 1 1 Veletural 2 Accident 3 Suicide	icant conditions	Hospital: 1 U 28e. Date (Mor) to be 28e. Place 28e. Pla	Inpetient 25 of Injury Year)	DER/Outpatien 28b. Time of Injury	nderlying ca	A Other	26. Place	o of Death (i	24a. Was perfo	Yes 2 No an autopsy med?  Yas 2 No ona) dence 6 □Oth- how injury occur  Street and Numb	3 Prod 24b. Wi av. co of 1 [	are autopsy finding aliable prior to mpletion of cause death?  Yes 2 140
to be completed by rhysicianym	Pert II. Other algnific  25. Was casa refarmaxaminer?  1 Yas 2 2 4  27. Manner of Death 1 10 Netural 2 Accident	icant conditions  red to medicat  No  5 Pending investiga 6 Could no	Hospital: 1 U 28e. Date (Mor) to be 28e. Place 28e. Pla	Inpetient 2E of Injury	DER/Outpatien 28b. Time of Injury	nderlying ca	A Other	26. Place	o of Death (i	24a. Was perfo	Yes 2 No an autopsy med?  Yas 2 No ona) dence 6 □Oth- how injury occur  Street and Numb	3 Prod 24b. Wi av. co of 1 [	are autopsy finding aliable prior to mpletion of cause death?  Yes 2 140
Certification: To Be Completed by Physician/M	25. Was casa referraxaminer? 1 Yes 25 Accident 3 Suicide 4 Homicide	icant conditions  red to medicat  No  5   Pending investige 6   Could no determine	Hospital: 1  28e. Data (Mor to be ed 28e. Place build  Physician: To the temples: On the b	Inpetient 2 Cof Injury - At It ing, etc. (Special best of my kmass of axamin.	ER/Outpatien  28b. Time of Injury  nome, farm, strify)	nderlying cannot see a s	A Othe  3c. tnjury  Work  1 1 1	26. Place  37: 4 Mill  41: 7: 4 Mill  48: 2 Mill  48: 2 Mill  48: 2 Mill  48: 4 Mill  48:	o of Death (dursing Home 286) No 286	24a. Was performed to the control of	Yes 2 No an autopsymmed?  Yas 2 No ona) dence 6 □Oth how injury occur  Street and Numb wn, State)	3 Prof	are autopsy finding aliable prior to mpletion of cause dasth?  Yes 2 No
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Monsh **Physician** 033AM 12, 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore City General Hospital Maryland 5. Social Security Number Year If Under 24 Hrs. 6. Sex 7. Age (in yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Hours Months Deys Min 217-48-0895 Usual Residence of Decedent Yrs. Director 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits 1 Ves 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23e or 23e-f si enty injury or other treaments. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces?

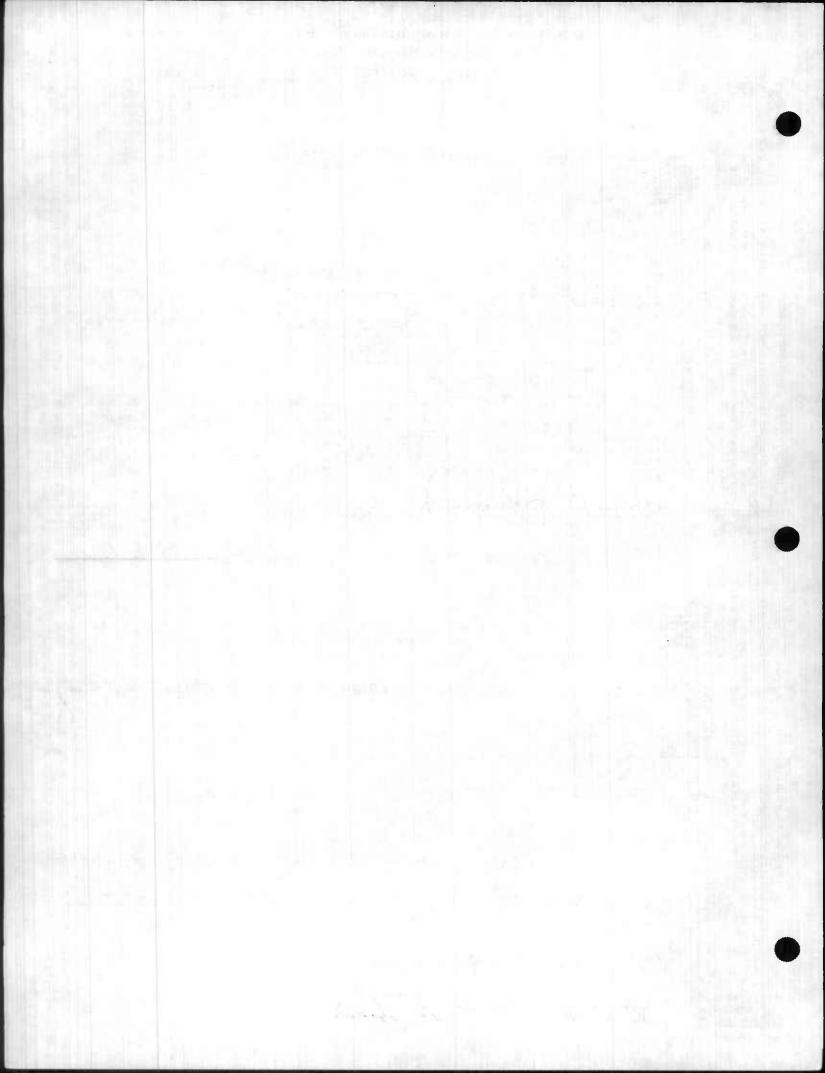
I Yes, Give Year or Date. 3302 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral View Never Married 2☐ Married 1 ☐ Yes 2 ☐ Yo Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Kez 17. Fether's Name (First, Middle, Last) NO per 18. Mother's Name (First, Middle, Maiden Sumame) KobeRI 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or 20b. Plece of Disposition (Name of cemetery, crematory or other place) 5. BAM. mp. & 20a. Method of Disposition 20c. Location - City or Town, State Date Burlat 2 Cremetion 3 Removal from State mt. Zion Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RATIS 23a. Pwr1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 177, AV 2013 Approximete Intervel Between Onset end Death Physician Immediate Cause (Final disease or condition resulting In death) 'ere brovascular /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, 2 Due to (or es e consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 DUnknown 1 Yes 2 No Division of Vital Records, à 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an eutopsy certificate has 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical exeminer? Certification: To Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpetlent 3 □ DOA This said 28c. Injury at Work? 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Affer Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in th 4 Homicide ò To the Fospital of Wilhin 24 hours at To the Funeral D completely filled it Medical 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/12/00 80. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Teneral Hospital KRPichar m.D. maryland 40 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

1 7 2000

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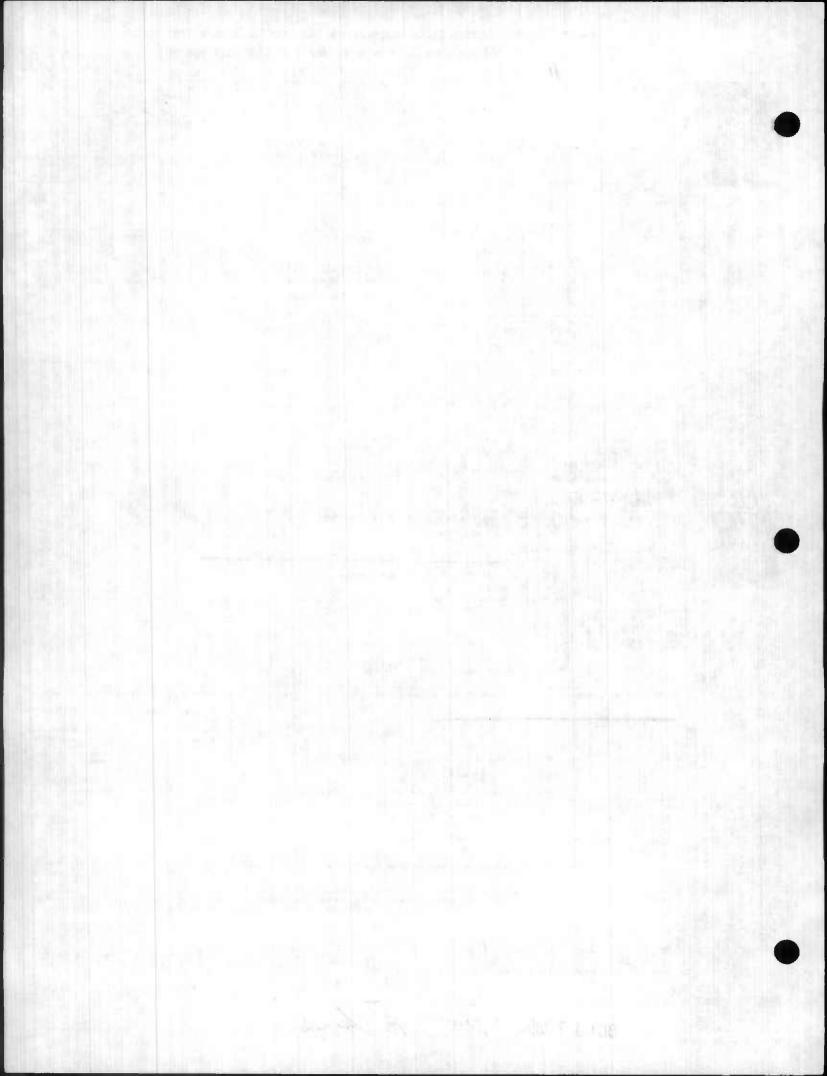
LOTT] JOHNS	Œ	nded AItem323apt11 perMFC	State of Mary	and / Depa	artment of h	Health and I	Mental Hyg	giene () ()	32699
No.	Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)	Lottie Le		nnson	4b. City, Town, or U	ocation of Death		
	uneral rector	5. Social Security Number 6. Sex		yrs. last birthday) 7 Yrs.	If Under 1 Yeer Months Days		8. Date of Birth (Month, Day 8-21-	7. Year) 9. 1943	Birthplace (State or Foreign Country)  Md
the Maryland	notified at rector	10a. State 10b. County Md N/A  10e. Street and Number		altimore	cation 10f. Zip Code			10g. Citizen of Wha	10d. Inside City Limits  VYes 2 □ No t Country?
20 s after death with	ut, or here 23e or 28e f s xeminer must be notified by Funeral Director	6810 Park Heigh  11. Maritel Stetus 1  1 Never Merried 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever Armed Forces? 1 Yes 2000 No		21215 Wes Decedent of If Yes, specify Cub	Hispanic Origin? (Sien, Mexican, Puert		U S A  14. Race -/ Black, V  Specify: {	Americen Indien, Mhite, etc. 31 ack
21215-0020 d within 72 hours at piene.	sother than "natural" event, the Medical Ex Be Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed)  College (1-4or 5+)  N / A	16a. Deced (Give life.		pation during most of world)	king	16b. Kind of Busin	ess/Industry Unk
should be filed	umerica other umeric event. To Be C	17. Father's Name (First, Middle, Last)  JOSEPH DOWNS  19a. Informant's Name/Relationship (Typ.		19b. Mailir	ng Address (Stree	Ella R	ichardso	Maiden Sumame)  On  or, City or Town, Sta	te, Zip Code)
altimore, Mi mit. Pages 1 and 2 partment of Heath a	ut: If flam 27 is ry or other tra	Eldora Christopher-  20a. Method of Disposition  1 \( \text{\text{M}} \) Burlal 2 \( \text{\text{Cremetion}} \) 3 \( \text{\text{Re}} \)  4 \( \text{\text{Donetion}} \) 5 \( \text{\text{Other}} \) (Specify)	20	b. Place of Dispo cemetery, crer		ice)	Baltin Date -29-00	nore, Md 2 20c. Location - City Lansdown	y or Town, State
Balti Permit.	ensy inju	21. Signature of Paperal Service Licetists	alman	L/	Name and Addr March F 4300 Wa	/H West bash Aven	ue Balt	imore, Mo	d 21215
/M	sician edical miner	Immediate Cause (Final disease or complik disease or condition resulting in death)	Arterioscle	erotic Ca	ardiovaso			17.	Interval Between Onset and Death
60, be exacuted	sician and buriel-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury C.		to (or as a consecto (or es a consec				0	
687	a bur	Cause (Disease or Injury that initiated events resulting in death) Last	Due	to (or as a conseq	juence of):				
P.O. at the	d by the elechex	Pert II. Other significant conditions cont Lung Cancer	ributing to death but no	t resulting in the u	nderlying ceuse gi	iven in Part I.			bute to the cause of death?  Probably 4 Unknown
Records, P	should thould						INSPE	med? CTION	44b. Were autopsy findings available prior to completion of ceuse of death?
Vital	rector rector	25. Was cese referred to medicel examiner? 1 ⊠ Yes 2 □ No	ospitel: 1  Inpatient	2 ☐ ER/Outpetier	nt 3 DOA OI	hae	eth (Check only o		1 ☐ Yes 2 ☐ No  (Specify) SCENE
ath.	r: After the funeral action:	27. Menner of Death  1 Noturel 5 Pending investigation  3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Yea	At home, ferm, str	M 1	Yes 2 No	28f. Location (S		or Rurel Route Number,
To the Hospital or within 24 hours afte	To the Funeral Directo completely filled in by the Medical Certific	29a. Certifier 1☐ Certifying Physi	building, etc. (St clen: To the best of my er: On the besis of examination of the besis of examination of the best of examination of the best of the b	knowledge, deatl				cause(s) end manne	
To the	To the	29b. Signature end title of certifier	11			se number		29d. Date signed (MEPTEMBER	
6	4	30. Name and address of person who does Theodore King M.D.		1		Street, 1		e, Maryla	
	State Registrar	31. Date filed (Month, Day, Year) OCT 1 7 2000	320 Registrar's S	S Harris	Sports				



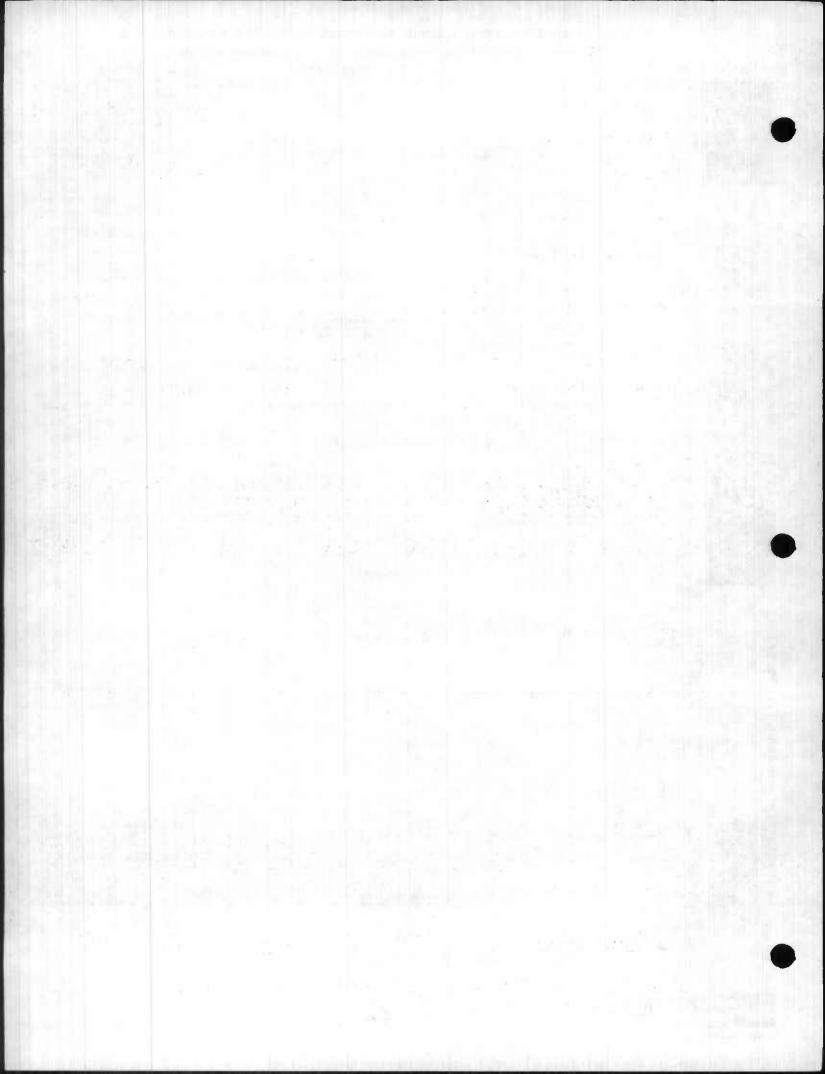
State of Maryland / Department of Health and Mental Hygiene 32700 Amended Item#23a perPHYG788 101/7/2000 EW Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth **Physician** KICHARD OCTOBER 2000 : 32 am CARL 10 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner GOOD - SAMARITAN - HOSPITAL BALTIHORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs. 24. 1938 213-36-3894 Dec. Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maruland N/A Baltimore 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code mant be n 5925 Arizona Avenue 21206 U. S. A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Detes: 14. Race - American Indien, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☑ Merried Baltimore, Maryland 21215-0020 8 1 ☐ Yes 2 No Specify: Àq 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementery/Secondary (0-12) College (1-4or 5+) Vendina 9th Grade Manager 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be es 1 and 2 should be 5 of Health and Mantal F Hem 27 is marked oil Irene T. Freiburger William W. Krause 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan E. Krause (Wife) 5925 Arizona Avenue, Baltimore, Maryland 21206 20b. Pleca of Disposition (Neme of cemetery, cremetory or other placa) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete Pages ment of h 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Meadowridge Memorial Park 10/12/00 Baltimore, Maryland 22. Name and Address of Fecility
Schimunek Funeral Home Inc. 21. Signeture of Funeral Service Licensee sny in 23a. Pert1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest,

Approximate YIRKT. A Approximete Interval Between Onset end Deeth **Physician** ESOPHAGEAL CANCER Immediate Ceuse (Finel diseese or condition resulting in deeth) /Medical ERSISTENT -Azillinisi Due to (or es e consequença of) Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or as a consequenca of): 68760 the Due to (or es a consequence of): Box P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by it 1 ☐ Yea 2 No 3 ☐ Probably 4 ☐ Unknown CANCER þ Records, 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en autopsy performed? Be Completed eged 1 Yea 2 No 1 Yes 2 No Division of Vital Hospital or Attanding Physician: 24 hours after deeth. Funeral Director; After this certifica etely filled in by the funeral director; I 25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No Yes 2 No 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of edical Certification: 5 Pending investigation 1 MNeturel 1 Yes 2 No 2 Accident 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a Cartifier 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifie 29c. License number also H.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. ALTAHA H.D. GOOD - SAMARITAN-BALTIMORE 31. Dete tiled (Month, Dey, Year) 32. Registrar's Signeture State Registrar



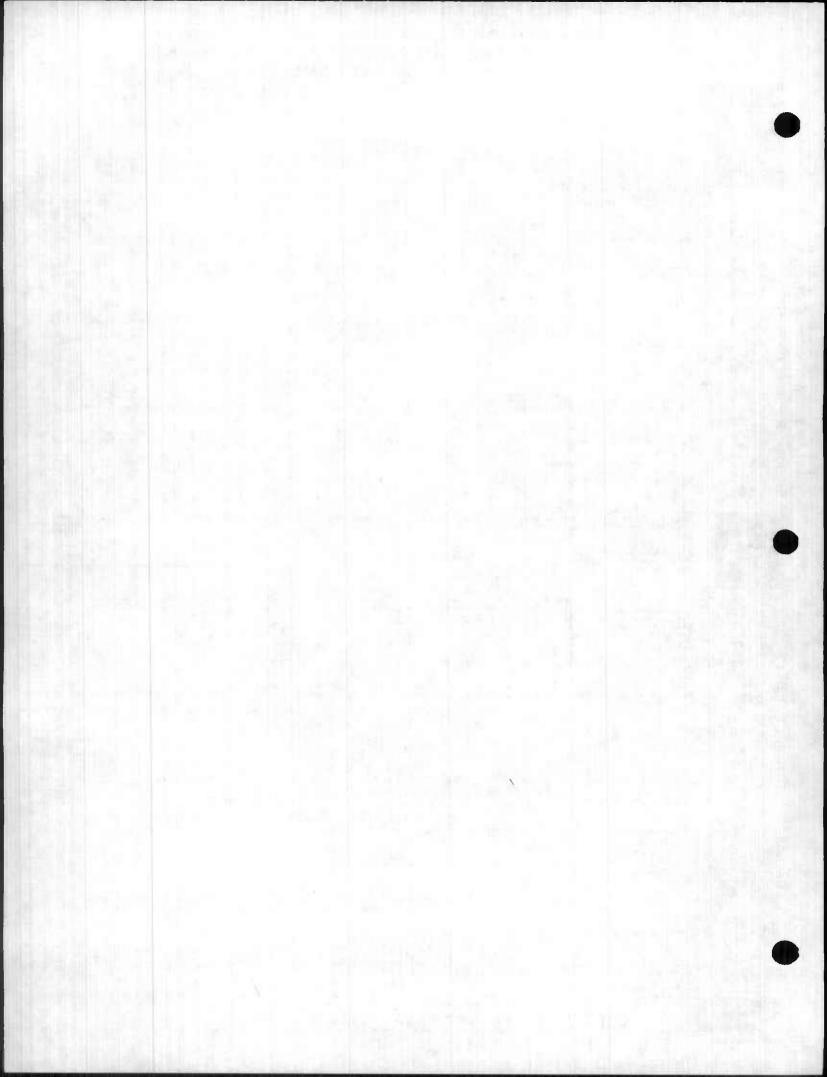
ELLA MAE KLINE    September 29, 2000   3:0	ended In	tEM #24a p		10/17/20				tificate					Reg	ene() () 1. No.	0 (	27(	J
48 Teachily Neems (if not institution, plus users and number)  40 Carry of Deems  40 Carr	•											Month		Day	Year 2000		of Death
Social Security Number   0. Series   10. County   10. C					nd number)								ath	4c. County	of Deeth		
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SWidowed & Discoad   Specify: Winite  150. Decoderly support of business in the support of business in	ren	11. Maritel Statu	S			Ever in U,S.	13. W	/as Decede			gin? (Spe	ecify Yes or	No-	14. Rac			1,
15. Decedent's Education   Specify only highest grades completed)   160 Decedent's Useal Coccupation   160 Rend of Business/Industry   160 Decedent's Useal Coccupation   160 Decements   160 Decem				ried 1 🗆	Yes 2 Nos. Give	lo					i, Puerto	rican, etc.)					
17. Father's Name (First, Models, Las)  19. Mother's Name (First, Models, Las)  19. Mother's Name (First, Models, Las)  19. Mother's Name (First, Models, Las)  19. David L. Dulaney  19. Informant's Name of David Control (Type, Print)  19. Informant's Name of David Control (Type, Print)  19. Informant's Name of David Control (Type, Print)  20. Mained of Disposition  1							16a. Deced	ent's Usual	Occup	etion			16	6b. Kind of Bu	usiness/ind	lustry	
17. Father's Name (First, Moddle, Last)   18. Mother's Name (First, Moddle, Malene Surmane)   19. Mother's Name (First, Moddle, Malene, Surmane)   19. Mother's Name (First, Mother'	Med aldr			T		+)	life. D	O NOT use	e retired	juring mos i)	t or worki	ng					
17. Father's Name (Frext, Middle, Last)   18. Mother's Name (Frext, Middle, Madele, Surface Surface)   19. David L. Dulaney   19. Mother's Name (Frext, Middle, Madele, Surface)   19. David L. Dulaney   19. Mother's Name (Frext, Middle, Madele, Surface)   19. David L. Dulaney   19. Mother's Name (Frext, Middle, Madele, Surface)   19. David L. Dulaney   19. David L	Com	10	0		_			cate	rer								
19s. Informent's Name/Reletionship (7)po, Pint) Unix 19s. Mailing Address (Street and Number or Rurel Route Number, City or Town, Steel. Zip Code)  20a. Method of Disposition   Date   20c. Location - City or Town, Steel Address (Street and Number or Rurel Route Number, City or Town, Steel Commettey, Crematory or other place)  20a. Method of Disposition   Date   20c. Location - City or Town, Steel Address of Facility   State   Anatomy Board   655 W. Baltimore Street   640 W. Baltimore   640 W. Baltimore Street   640 W. Baltimore   6	9 9														10)		
20a. Method of Disposition    Burial 2   Cremation 3   Removal from State     Immediate Cremic (fining resulting in deeth) Lost only one cause on each income     Burial 2   Cremation 3   Removal from State     Due to (or es e consequence of):     Due to (or es e consequence of):     Cremation 5   Cremation 5   Cremation 5     Cremation 6   Crem	To To			,		• 1											
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21. Segmenture of Fundatal Service Licensee  22. Name and Address of Facility  23. Part I. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, inches the disease. It is not not cause on each line.  23. Part I. Either the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, inches the disease or condition that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, inches the disease or condition resulting in deeth).  25. Sequentially list conditions, an inches devents in resulting in deeth). Lest  26. Due to (or es e consequence of):  27. Manne and Address of Facility.  28. Part I. Either the disease or condition as conditions and inches devents in the cause of the death. Do not enter the mode of dying, such as cardiac or respiretory errest, inches the cause (final disease or condition and inches devents in inches devents in inches devents in inches devents in resulting in deeth). Lest  28. Sequentially list conditions, an inches devents in resulting in deeth) Lest  29. Due to (or es e consequence of):  24. Due to (or es e consequence of):  24. Were an autoppy performer?  24. Was an autoppy performer?  25. Was case referred to medical avanities.  26. Place of Death (Check only one)  26. Place of Death (Check only one)  27. Mappear of Death (Preck only one)  28. Location (Street and Number or Furrel Route I Death of Injury of I	or other	1 D Burial	2 Cremation					:e)		Date 20c. Location - City or Town, Stete					9		
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State of Maryland / Department of Health and Mental Hygiene

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	Cert	rificate of Death	Reg.	. No.	02702
	Decedent's Neme (First, Middle, Last)		2. Date of Death Month	Day Yeer	3. Time of Death
ysician Iedical	Helen Knight			11, 2000	2:10 AM
niner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Li	-	4c. County of Death	
	CHARLESTOWN CARE CENTER	CATON	SVILLE	BALT	IMORE
	Social Security Number	If Under 1 Yeer If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Dey, Ye	9. Birth	plece (State or Foreigntry)
r	215-05-5660 1 <sup>1</sup> M XDF 89 Yrs.	Months Days Hours Mill.			RYLAND
	Usual Residence of Decedent			1	
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cto	MARYLAND BALTIMORE CATON	NSVILLE			1 ☐ Yes 🗶 ☐ N
Directo	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Cou	intry?
=	711 MAIDEN CHOICE LANE	21228		U.S.A.	
Funer	11. Marital Status 12. Was Decedent Ever In U,S. 13. W	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Raca - Ameri Black, White	
	1 Never Married 2 Merried 1 Yes XX No	☐ Yes 2 No Specify:		Specify:	
d by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:			WH	ITE
petel	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give ki	ent's Usuel Occupation ind of work done during most of work O NOT use retired)	ing 16l	b. Kind of Business/Ir	ndustry
Сотр	Elementery/Secondary (0-12) College (1-4or 5+)	O NOT use retired)			
S		KEEPER		AINTING C	ONTRACTOR
Be	17. Fether's Name (First, Middle, Last)		e (First, Middle, Mai		
10	BENJAMIN WACH!			SEIB	
		Address (Street end Number or Rui			
		SHOOKSTOWN ROAD,			
				c. Location - City or T	
	4 □ Donetion 5 □ Other (Specify) CHESAPEAR	E CREMATION CENTE	R, LLC S	TEVENSVIL	LE, MD.
	21. Signature of Fullana Service Ligensee 22.	Name and Address of Facility	INGLETON	FUNERAL H	OME, P.A.
	Tayl tagan 1	SECOND AVENUE, S	.W., GLEN	BURNIE,	MD. 21061
	23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter shock, or heart feilure. List only one cause on each line.	r the mode of dying, such es cardiac	or respiratory arrest		Approximate Interval Between
					Onset and Death
	Immediate Cause (Finel disease or condition	119			Day 5
	resulting in deeth)  Due to (or as a consequ	ence of):			
ine	Alzeheim	er's Dises	21		
Examiner	Sequentially list conditions, Due to (or as a consequ	enca of):			
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by			24a. Was en a	24h V	Vere autopsy finding
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cat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	206 Landing (Ctos	at and Number as Du	m I Coute Number
틭	4 Homicide  4 Homicide  4 Homicide  28e. Plece of Injury - At home, farm, street building, etc. (Specify)	et, factory, offica	City or Town, S	et and Number or Ru Stete)	rei Houle Number,
2					
edical	29a. Certifier  (Check only  2 Medical Examiner) On the basis of examination and/or investigation.	occurred et the time, date end plece, estigation, in my opinion, deeth occur	end due to the caus red at the time, dete	se(s) and manner as end piece, and due	stated. to the cause(s)
Med	29b. Signeture and tible of certifier	29c. License number	204	. Date signed (Month	Day Veer)
		D 47447			
	, mo	17.	C	)CICYUN I	2000
4	30. Name and address of posson who completed cause of deeth (Item 23e) (Type, P	rint) Choice	Lane	Con	insville
411	The City ///	1410-1010			
		1.			
State egistrar	30. Name and address of person who completed cause of deeth (Item 23e) (Type, P	Taich Choice	Cone	October 1	



Physicia /Medic Examine	al	SME/ la Facility Neme (	B. L (If not institution, gi	EWIS  iva street end number  Polen	NUR	aina Homs	4b. City, Town, or L	ocation of Death	22-20 4c. County		30 A. M
Funeral Director		Social Security I	3 -3583	Sex 7. /	Age (In yrs. last		r If Under 24 Hrs.	8. Data of Birth (Month, Dey,	Year) 9/6	9. Birthplaca (Stete Country)	or Foreign
e Maryland le-f show diffed at	-	Md. Stele	10b. County			own or Location				10d. Inside	City Limits 35 2 □ No
ms 23e or 2 must be ns	ral Di	10e. Street and Nu  /83  1. Marital Status		12. Wes Deceder	A.		/220 Hispanic Origin? (Sp			Mhat Country?  S. A e - American Indian,	
0020 Dury after d	1 by Fun		ried 28 Merried 4 Divorced	Armed Force	S?	13. Was Decedent of If Yes, specity Cul	_	o Rican, etc.)		ck, White, etc.	800
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Maryland 21215-0020 d 2 should be filed within 72 hours all th and Merital Hygiene. The marked other than "natural", or traumatic event, the Medical Exami	To Be Co	17. Fathar's Name	Wirst, Middla, Las				18. Mother's Nam	ne (First, Middle, N	Naiden Sumam		
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Baltimore Jemit, Pages 1-4 Department of He Important: If Hem Inty Injury or other		1 ☑ Burial 2 4 ☐ Donetion	•	**	10 /	2 butus Ma 22. Name end Addi	Em.	8/27/2000 Bette	ARI	botos M.	eryla
M FORES		23e. Perti. Enter	the disease, or cor	mplications that caus	sed the deeth. [	1/24 1/-	CAROLIA vino such as cardiac		Bal	to. Md.	2121.
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Physician /Medical // Examiner		Immediete Cause disease or conditi- resulting In death)	on	a Smo	the 1	nhalatin	mth	collaps	e lin	Intervel E Onset an	etween
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Division of Vital Records, P.O. Box 68760,  • Hospital or Attanding Physician: The law requires that the deeth certificate be executed in 24 hours after deeth.  • Funeral Director: After this certificate has been signed by the attending physicien and plately filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Certification: To Be Completed by Physician/Medical Examiner	disease or conditive sulting in death)  Sequentially list or if any, leading to it cause. Enter full cause. Enter full cause (Disease or thet initiated event resulting in death)  Part II. Other eigning the cause of the cause (Disease or the cause (Disease or the cause) in death)  Part II. Other eigning the cause of	onditions, mmediate lerlying rinjury is Last liftcant conditions  arred to medical liftcant conditions  by the conditions of con	a. Smooth and the second and the sec	Due to (or estable of examination stated.	And the state of t	26. Plece of Dee Other: 4 Nursing H ury et ork? Ves 2 MNo	24e. Wes an perform 1 Ve ath (Check only on Housefil 28d. Describe how the carried et the time, did not be the carried et the carried et the time, did not be the carried et t	the limit of the l	Intervel E Onset an Onset Onse	e(s)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend Item#26 perPhyG788 10/17/2000 EW 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 7, 2000 **Physician** Jeannette M. Lindner 8:30 am /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner Harford 203 Duncannon Road Bel Air 7. Age (In yrs. last birthday) If Under 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Day, Yeer) September 30, Birthplace (State or Foreign Country)
 MD 5. Social Security Number **Funeral** Days Hours Months 1 M 2 XF Vre 64 212-34-7641 1936 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No MD N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5400 Hamlet Avenue 21214 U.S.A. death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forcas? 11 Marital Status filed within 72 hours after 1 Yes 2 No tf Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White P 3 ₩ Widowed 4 Divorced Completed Decadent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Annulment Administrator Catholic Church 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 end 2 should be fill mant of Health end Mantal Hant: If item 27 ia marked oth jury or other traumatic even Be John Adam Schreiber Johanna Moeller 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Gerard M. Lindner-son 203 Duncannon Rd., Bel Air, MD 21014 20b. Pleca of Disposition (Name of cemetery, crematory or other placa) 20e. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any injury or pace. Most Holv Redeemer Cemetery 10/11/00 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee William G. Dau 22. Nama and Addrass of Facility
Leonard J. Ruck Funeral Home, Inc.
5305 Harford Rd., Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner requires that the death certificate be axecuted physician and the burial-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consaquanca of): 80 for use es ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed to by 24b. Were eutopsy findings available prior to completion of causa of death? should b 24a. Was an autopsy performed? Completed cartificate has b 2 No 1 ☐ Yes or Attending Physician: director, 25. Wes case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nother (Specify) Son s Home 1☐ Yes 2 No 10 this funeral 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 2 Accident 5 Pending investigation 1∏ Yes 2∏No r death. ector: 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 Could not be 3 ☐ Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by Dire 4 Homlcide 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and placa, and due to the causa(s) end manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the causa(s) and manner stated. edical 29a. Certifier (Check only

State Registra

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

eddress of person who completed cause of death (Item 23a) (Type, Print)

Millermo

29b Signature and title of certifie

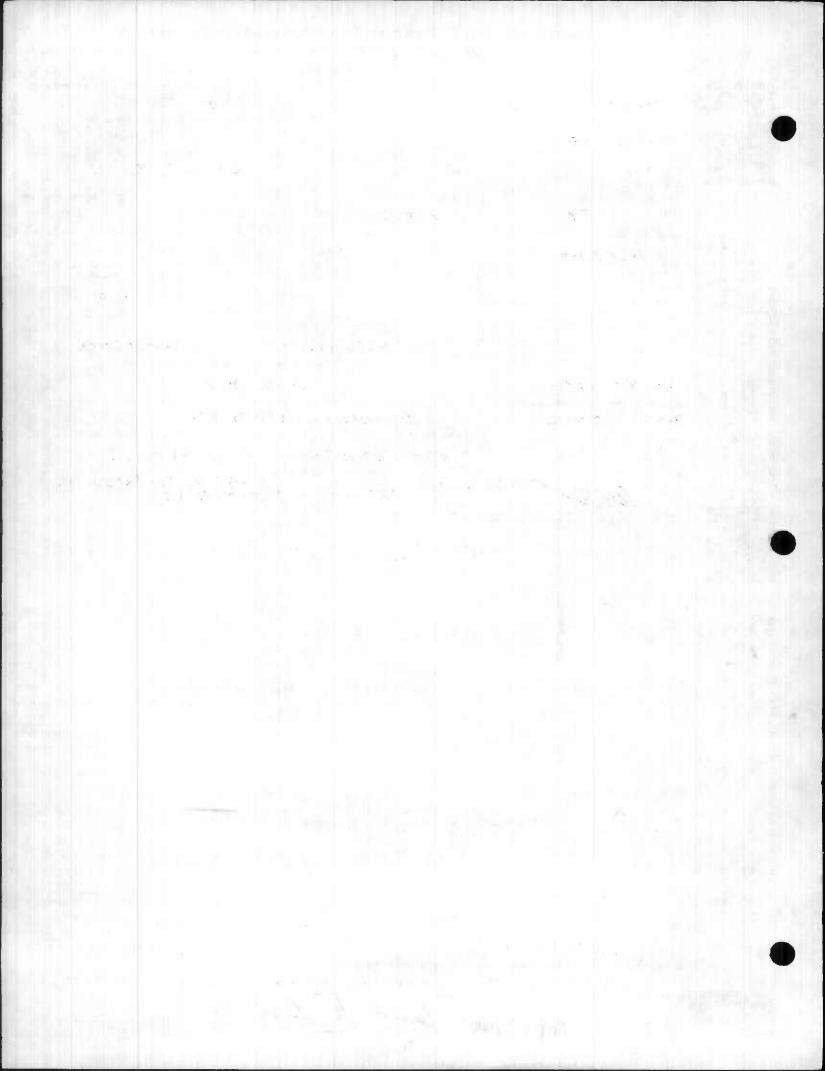
31. Dete filed (Month, Dey, Year)

Marole

D Bunting Blaustein Concer Res Blds 1650 OrleansSt BAUT My 2123)

29c. Licensa number

29d. Date signed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** James Little 12:00pm Oct. 13, 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Baltimore 1703 Payson Street If Under 1 Yeer If Under 24 Hrs 5. Sociel Security Number Birthpleca (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** XXM 2 F Months Deys Hours 63 Yrs. SC 250-58-2490 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "naturel", or Items 23s or 28s-f show 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits maint be notified at Yes 2□No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1703 Payson Street 21217 USA Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☑ Merried 21215-0020 1 ☐ Yes 2 No Specify. Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Hygiene. Southern Elementary/Secondary (0-12) College (1-4or 5+) Galvinizing 5th Grade NA Steel Cleaner Maryland 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be McDuffie Gibbs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21217 19a. Informent's Neme/Relationship (Type, Print) 1703 Payson Street Baltimore, Maryland Little other Baltimore, 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removel from State permit. Page Department of Important: If eny Injury or once. 9 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Pk. Cem. 10-19-2000 Randallstown, MD 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, of complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. B WM.C.March FH 1101 E. North Avenue Approximate tnterval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the buriel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 2 1 Yes 2 No 3 Probably 4 Unknown Medical Certification: To Be Completed by Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 should this certificate has 1 Yes 20 No 1 Yes 2 No of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1□ Yes av No Other: 4 Nursing Home 5 Residence 6 Other (Specify) tha funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Aftar Division Natural 2 Accident 5 Pending investigation aftar death. 1 Yes 2 No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 \ Homicide To the Hospital within 24 hours a To the Funeral C Hospital The Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29b. Signature and title of cartifier 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

State Registrar ani

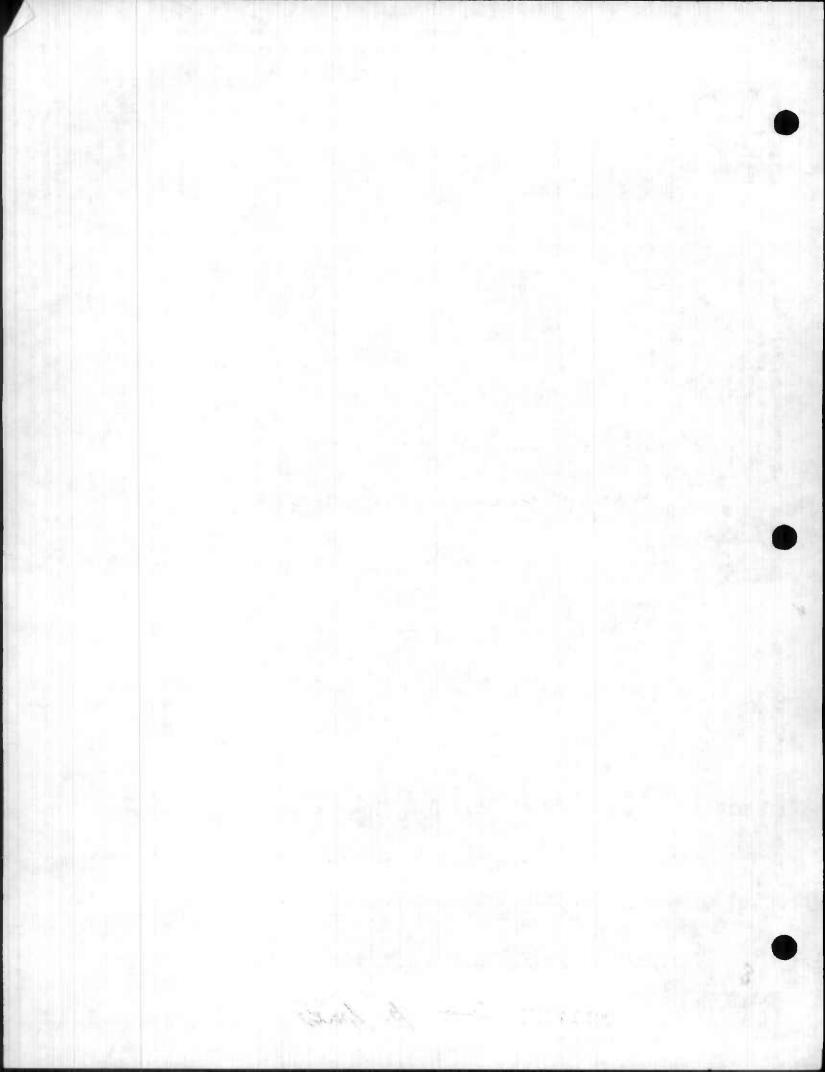
31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

ORIGINAL

82. Registrar's Signature

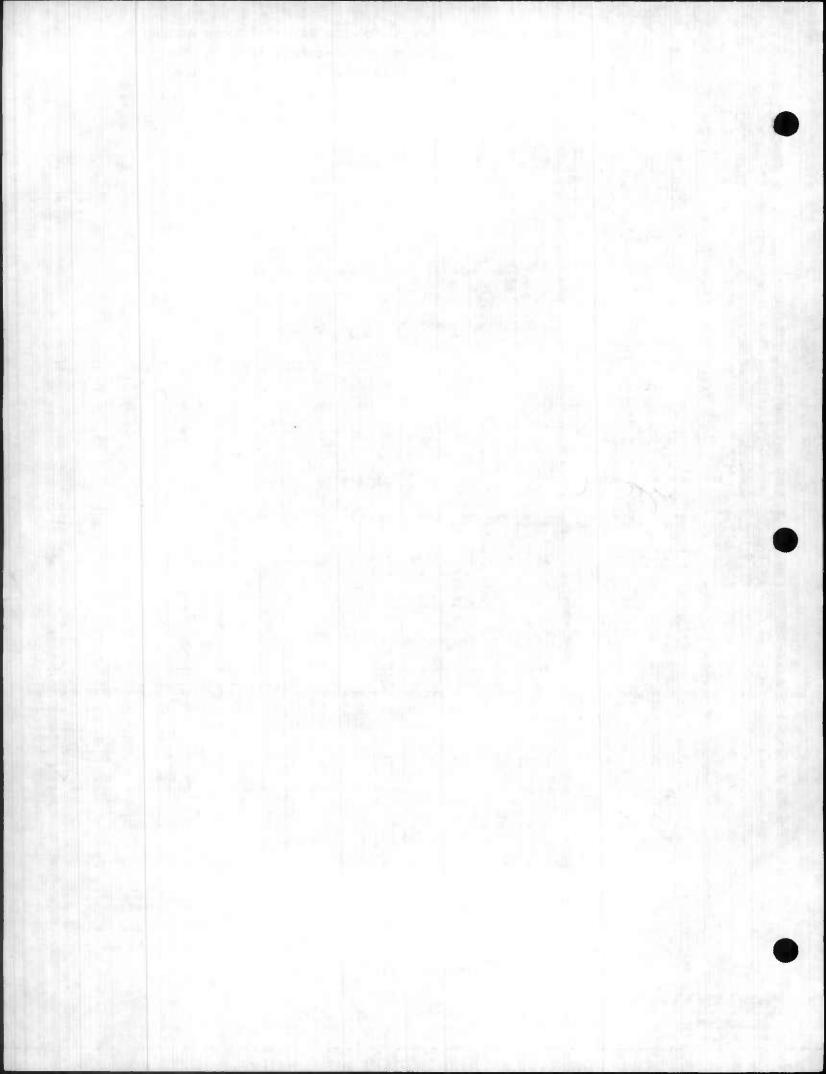
2000



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State of Maryland / Department of Health and Mental Hygiene 0 0 3 2 7 0 6

			Certifica	te of	Death	F	leg. No.	0 12 7 0 0
	Decedent's Name (First, Middle, Last)	15 170 (10)				2. Date of Dea Month		3. Time of Death
Physician /Medical	Adda Leland							2000 10:34p
Examiner	4e Facility Name (If not institution, give street end numb	er)			4b. City, Town, o	Location of Death	4c. County of	
	Greater Baltimore Med	ical Ce	nter		Towson		Balti	more
° Funeral	5. Social Security Number 6. Sex 7.	Age (In yrs. last b	Months	or 1 Year Days	Hours Min	8. Date of Birth	Year)	Birthplace (State or Foreign Country)
Director	217-18-9522	81	Yrs.			April 1	0,1919	WV
2 .	Usual Residence of Decedent  10a. Stete 10b. County	10c City To	wn or Location					10d. Inside City Limits
anyle anyle		100. 0.1, 10						1 ☐ Yes 2 No
or 18a-f	MD Baltimore  10e. Street and Number		Timonium	n ip Code			Og. Citizen of Wh	et Country?
			101. 2				A contract	
her death viner ribers 23 siner must	2300 Dulaney Valley Road		13 Was Dec	2109		Specify Yes or No-	USA 14 Bace -	American Indian,
the part of	1 Never Married 2 Married 1 Yes 2	BS?				Specify Yes or No- rto Rican, etc.)	Black,	White, etc.
d 2 should be filed within 72 hours at th and Mental Hygiene. 7 is merited other than "netural", or traumetic event, the Medical Exams To Be Completed by F	3 Widowed 4 Divorced Year or Date		1 ☐ Yes	210 No	Specify:		Specify:	White
	15. Decedent's Education	16	e. Decedent's Us	ual Occup	pation		16b. Kind of Busi	ness/Industry
wythen.  We then *netur  It, the Medical.  Completed	(Specify only highest grede completed)  Elementery/Secondery (0-12) College (1-4	05.51)	(Give kind of w life. DO NOT	ork done use retire	duning most of w d)	orking		
the state of the s	12 N/A	01 3+)	Secre	tary			In	surance
tal Hyge d other event, Be C	17. Father's Name (First, Middle, Last)		8 7 34 1		18. Mother's N	ame (First, Middle,	Maiden Sumeme)	
Menta of	Herbert K. Leland				Eli	zabeth C	. Heald	
O DE L	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing Addres	ss (Street	end Number or i	Pural Route Numbe	r, City or Town, Si	ate, Zip Code)
27,000	Donald M. Delcher/ Nephew	P.	O. Box	5333	Timon	ium, MD 2	1094	
- See	20a. Method of Disposition	20b Place cemer	of Disposition (No	ame of	ce)	Dete	20c. Location - C	ty or Town, State
Page 17 or 17 or 1	1 △ Buriel 2 □ Cremation 3 □ Removal from Sta 4 □ Donetion 5 □ Other (Specify)	Druic	lery, cremetory or I Ridge	Cemet	téry	Oct. 16 2000	Balti	more, MD
and	21. Signeture of Funeral Service Licensee		22. Name a	and Addre	ess of Facility	,		
SEES	Michael Michael	T Flool						ley, Inc.
	Michael 23a. Part1. Enter the disease, or complications that cau					d Timoniu		Approximete
Physician	shock, or heart feilure. List only one ceuse on eed	h line.						tnterval Between Onset and Death
/Medical	Immediate Cause (Final	(1)		0 1		Dileas		110005
Examiner	disease or condition resulting in death)	ric Obs	a consequence of		moraly	Direase		years
9		200 10 (01 03 1	a consequence of	,.				
letan and burial-transit	Sequentially list conditions	Due to (or as a	a consequence of	):		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	12.5	
Ex Ex	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c							
physician is the buris	Cause (Disease or Injury that initieted events resulting in death) Last	Due to (or as a	consequence of	):				
as the	resuming in death) cast							
attendir for use	d							
the atte	Part II. Other significant conditions contributing to deat	h but not resulting	in the underlying	ceuse gi	ven in Part I.	23b. Dld t	obacco usa conti	ributa to the cause of death?
4 a	Atrial Flutter					104	2 2 No 3	Probably 4 Unknown
be det	- Mirial Flotter							
v requires mat me cean centricate be assect been signed by the attending physician and should be detached for use as the burial-tranleted by Physician/Medical Exan							en autopsy med?	24b. Were autopsy findings available prior to
25.5								completion of cause of death?
ate ha						101	es 20 No	1 ☐ Yes 2 No
certificate rector, pag	25. Was cese referred to medicat				26. Place of D	eeth (Check only o	ne)	
Z 00 0	examiner? 1 Yes 2000 Hospital: 1000	atient 2 ER/C	Outpatient 3 0	DOA Ot	her: 4 Nursing	Home 5 Resid	ence 6 Other	(Specify)
After thi funeral funeral	27. Manner of Death  1 Neture 5 Pending (Month,	Injury 28b	. Time of Injury	28c. Inju	ry at	28d. Describe h	ow injury occurred	d
Attending or death. ector: Alter by the fune iffication:	2 Accident investigation		M		Yes 2□No			
er de recto by ti by ti	3 Suicide 6 Could not be determined 28e. Plece of building	Injury - At home, , etc. (Specify)	farm, street, fecto	ry, office		28f. Location (S City or Tox		or Rurel Route Number,
Safe of in		, , , , , , , , , , , , , , , , ,						
Ne Hospital or Attending P 24 hours after death Ne Funeral Director: After to placety filled in by the funeral edical Certification:	29a. Certifier (Check only 2 ■ Medicaf Examinar: On the basi							
B 2 2 H	one) 2 Medicar Examinar: On the basi	r stated.						
A STATE OF THE STA	29b. Signature and title of certifier		2		se number	4,4		(Month, Dey, Year)
rol	> My milder			13	1789		10/13	00
740	30. Name and address of person who completed cause	of death (Item 23a	(Type, Print)		J. FD	1.10		
	MG Melderf, 6565 N. C.	varles St	, Suite 20	3,1	anson,	M1) 51.	204	
State	31. Date filed (Month, Day, Year) 32. Reg	istrar's Signature	1	1	./ .			
Registrar	OCT 17 2000	22yossid	D. 1	pou	Kel			

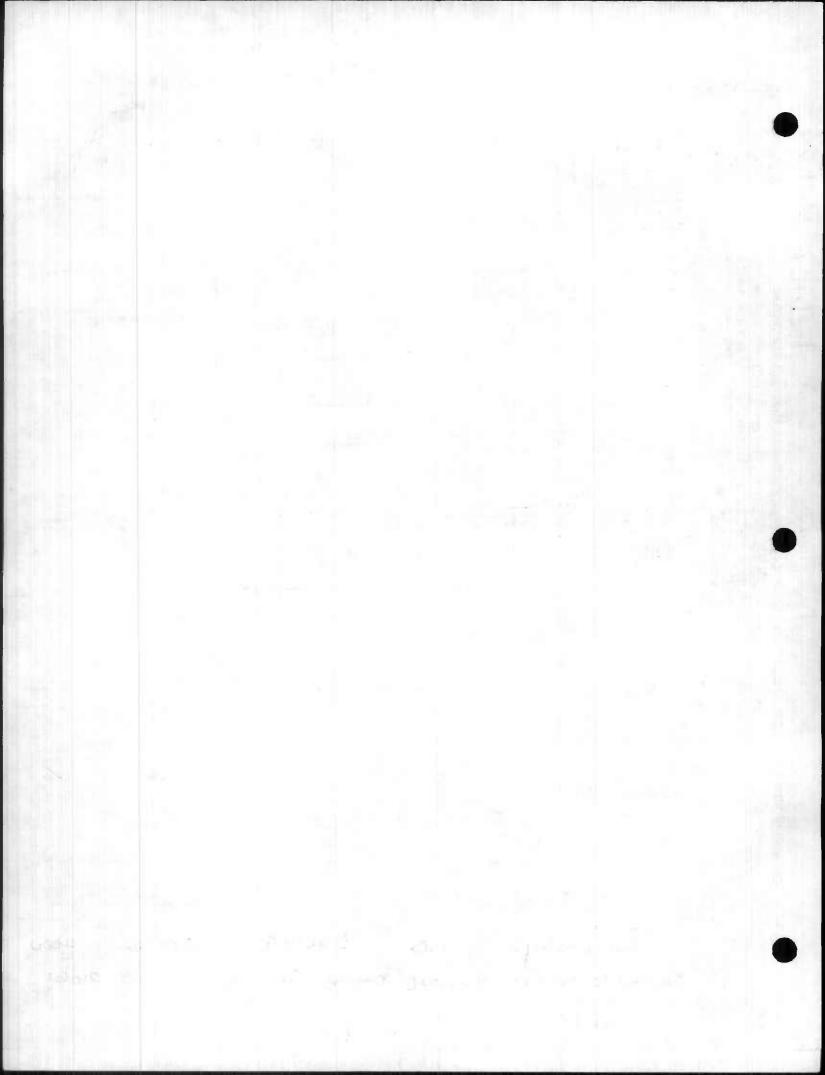


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State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** . 2000 10.45 Pm HELEN MELLOR OCTOBER 11 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Hospital Burnie Arun de Arundel Anne Hours Min. 8. Data of Birth (Month, Day, Year) OCT 17, 1 If Under 1 Year last birthday) 5. Social Security Number 6. Sex 7. Age (In yrs. Birthplace (Stata or Foreign Country) **Funeral** Months 1 M 2 ₹ F 78 Yrs. 214-20-2061 1921 MARYLAND Director Usual Rasidanca of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Directo MARYLAND ANNE ARUNDEL SEVERN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð 854 REECE ROAD 21144 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 11 Marital Status 1 Nevar Married 2 Married 8 1 Yes 2 No Specify: WHITE Specify: p 3X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) 12 SALES CLERK DEPARTMENT STORE Baltimore, Maryland 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) 2 should be fit and Mental F Be CHARLES GARDNER BERTHA SANFORD Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) RICHARD MELLOR (SON) 1935 CODD AVENUE, BALTIMORE, MARYLAND 21222 or other tr 10/16/2000 Location - City or Town, Stata 20b. Place of Disposition (Name of camatary, crematory or other place) 20a. Mathod of Disposition ō Burial 2 Cramation 3 Ramoval from Stafa 4 ☐ Donation 5 ☐ Othar (Specify) MARYLAND VETERANS CEMETERY CROWNSVILLE, MD. 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 margar art1. Entar tha diseasa, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, nock, or heart failura. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** Immediata Causa (Final disease or condition rasulting In daath) /Medical LOBAZ. PHEUMONIA Examiner Examiner BREAST CANCER METASTATIZ ician and burial-transit Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): physician s the burial Box 68760. that the death cartificate be Physician/Medical Due to (or as a consequence of): esn signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 | Yes 2 | No 3 | Probably 4 | Unknown Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? should s 24a. Was an autopsy Completed page 2 1 ☐ Yes 2 ☑ No 1 Yes 2 No of Vital 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Division or Attending 5 Pending invastigation Houpital or Attending 24 hours after death.
Funeral Director: After the funeral process. 1 Tyes 2 No 2 ☐ Accident 6 Could not be detarmined 28a. Place of Injury - At home, farm, street, lactory, office building, atc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. edicai (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Wildin 2 To the 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 401 020BB2 11. 2000 MIS 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) Glen Barnie ONARATO 8 びもくち 21061 201 HOS PITAL 32. Registrar's Signatura State Registrar 17 2000

**DHMH 16 Rev 6/95** 

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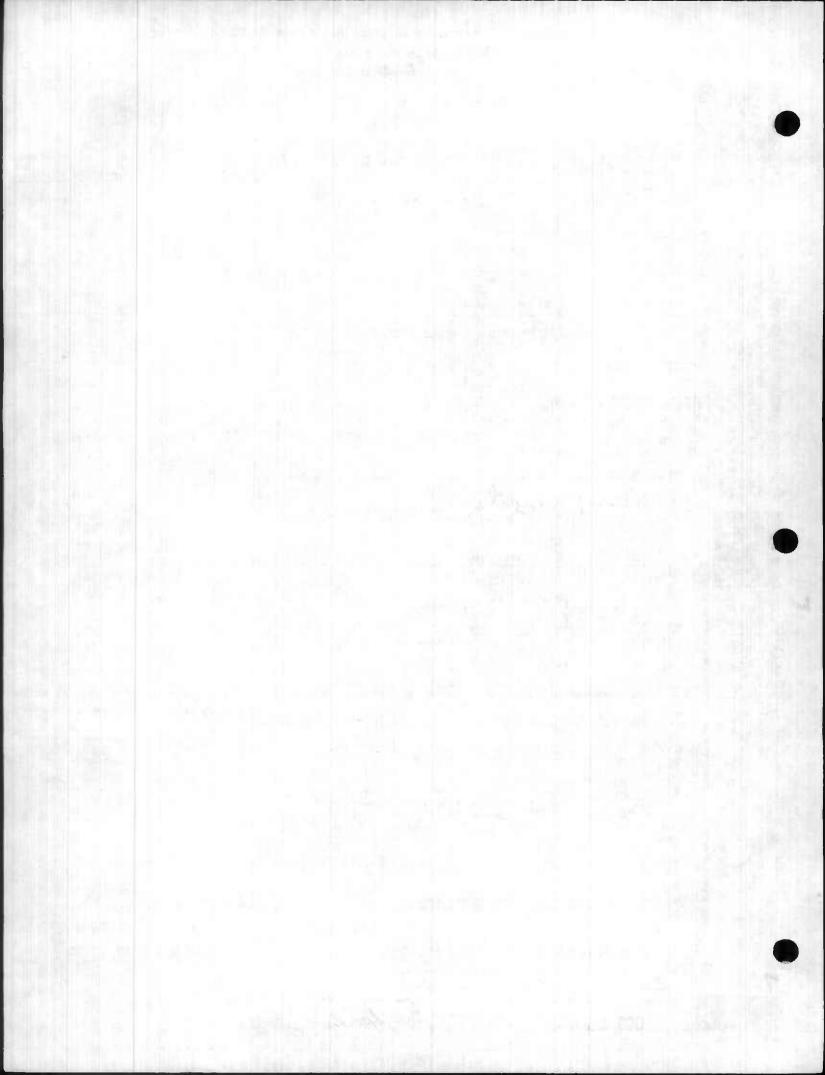


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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	Funeral Director		5. Social Security N 241-30-	9416	3. Sex 1 □ M 2 🖄 F		76 Yrs.	Months D	ear ays	If Under 2 Hours	Min.	8. Date of Bi (Month, Di April	th ey, Year) 7, 19	24		h Cari	
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	e Marylar Be-f show		Md .	10b. County	N/A	106.	City, Town or t		tim	nore C	ity						2 No
	ifier death with the Mar r frems 23s or 28s-fs inher must be notified		10e. Street and Nu		23 Wilke	Avenu	е	10f. Zip Co	de	21206					het Count	•	
	Seatt 2	5	11. Meritei Stetus			cedent Ever in	U,S. 13	. Was Deceden If Yes, specify	t of H	lispanic Orig	in? (Sp	ecity Yes or N	0- 1	14. Reca	- America	an Indien,	
020	and and a	5	1 Never Marr	ied 2 Marrie	Armed I  1 Yes, 0  Year or	2 X No Give	9	If Yes, specify  1 ☐ Yes 2 ②			Puerto	Rican, etc.)		Bleck Specify:	k, White, e	White	
21215-0020	led within 72 horygiene.  ner then "neturn"	ובופת	(Spec	15. Decedent's cify only highest	Education grade completed	d)	(Giv	edent's Usual C e kind of work of DO NOT use i	tone	during most	of work	ing	16b. Kir	nd of Bu	siness/Ind	ustry	
	d withi	2	Elementary/Seco	2 ondary (0-12)	College	(1-4or 5+)		nbly Lir		,	r		Ele	ectr	onics		
Maryland	Mental H irked off afficever		17. Father's Name	(First, Middle, La		y Pearc	e			18. Mothe		e (First, Middle ZZIE Al		Sumam	9)		
	1 end 2 sho Health and I em 27 is me ither traum												21206				
Baltimore	permit. Pages 1 end Depertment of Health Important: If Item 27 any Injury or other to ance.	4	1 🗆 Burial 2	a. Method of Disposition  1 Burial 2 Cremetion 3 Removal from State  4 Donation 5 Other (Specify)  20b. Placa of Disposition (Name of cametory, cremetory or other place)  Hilltop Service Corp.  Date  20c. Location - City or Town, State  Towson, Maryland													
Balt	permit. Pag Depertment Important: I any Injury o		21. Signeture of Funeral Service Licensee Milton J Knight Jr 22. Name end Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214														4
			23a. Part1. Enter t	the disease, or co	omplications ha	t caused the de								3		Approximati	te
	Physician /Medical Examiner		Immediete Cause disease or condition	(Finel				CANCE								Onset and	Death
		010	Due to (or as a consequence of):														
68760,		Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):															
Box 6	th certific tending p or use es				d												
P.O. E	the death y the atter ched for u		Part II. Other signif	ficant condition	s contributing to	death but not r	resulting in the	underlying caus	se giv	ven in Pert I.			1			the causa	
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of Vital Records,	The law requires that the death again has been signed by the attent page 2 should be detached for uncontained by Dhysiciles	2000	MITTERL	USZLE	MOTIL	Long	WVBSL	ulm -	DI.	seas.	ह	24a. Wa peri	s an autop ormed?	osy	eve	re autopsy ilable prior npletion of d death?	to
E B	Physician: The lavithis certificate has al director, page 2											1 🗆	Yes 2	No	10	Yes 2	] No
Vita	Physician: rthis certific aral director,	2	25. Was case referexaminer?		Hospitel:				Ott	hor:		h (Check only					
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ion	Attending For death.  sctor: After by the funerities.		27. Menner of Deat 10 SNatural 2 ☐ Accident	5 Pending investiga	(Mc	e of Injury onth, Dey Year,	28b. Time injury	M 280	Woo	rk?  Yes 2∐	No	28d. Describe	now injur	y occuri	<del>0</del> 0		
Division	tal or Attending P is after death.  al Director: After tied in by the funera		3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	Ad 208. Pla	ce of Injury - Alding, etc. (Spe	t home, farm, s	street, factory, o	ffice			281. Location City or To	(Street en own, Stete		er or Rura	Route Nun	nber,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Madical Cartification.		29a. Certifier (Check only one)	Certifying 2 Medical Ex	Physician: To the caminer: On the and ma	he best of my k basis of exami anner stated.	knowledge, dee ination and/or	oth occurred et investigation, in	the time	me, date and opinion, deat	d plece, th occur	end due to the red at the time	ceuse(s) , date and	and me	nner as st and due to	ated. the cause(	s)
	To the comp	-	29b. Signature and	I title of certifier	1 1	000	10	29c. L	icens	se number			29d. Dat	e signe	d (Month, i	Dey, Year)	HAT
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	7		PENE	LONS /				Print)	RE	new.	sur	D, BALT	mon	131	ND 3	2123	9
	State		31. Date filed (Mon	th, Day, Year)	32.	Registrar's Sig	gnature	1	, 4	al							
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DHMH 16 Rev 6/95



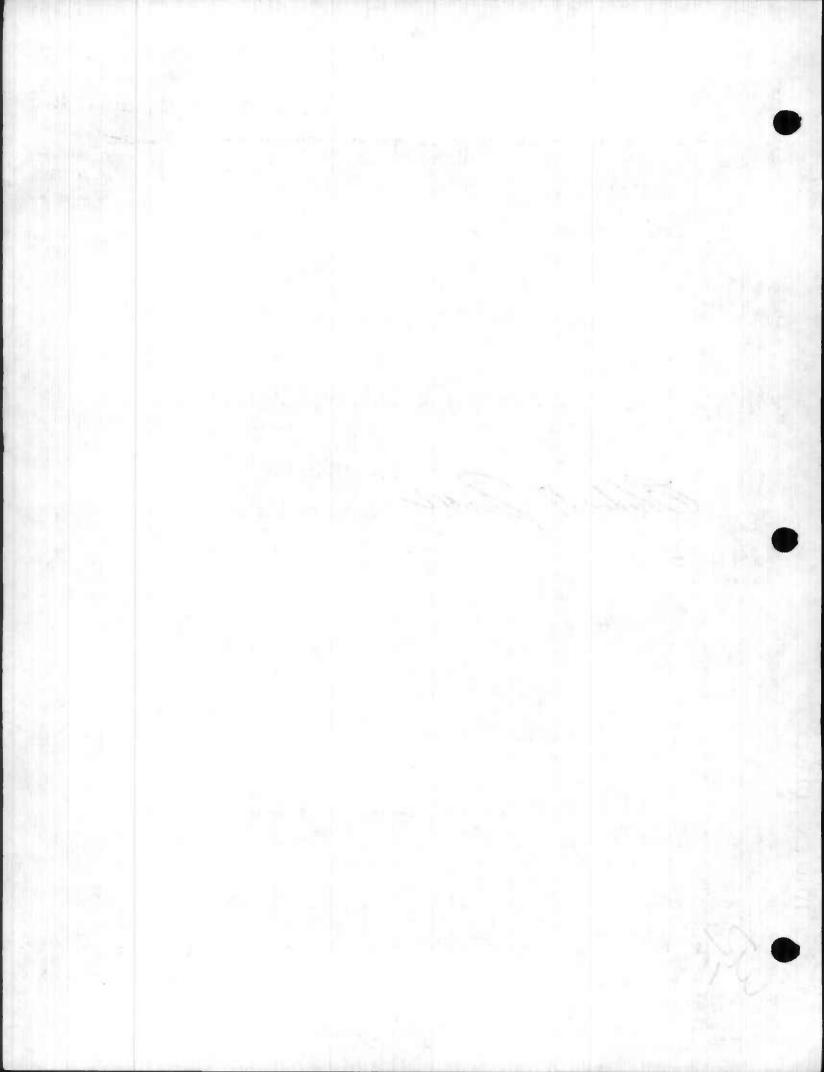
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State of Maryland / Department of Health and Mental Hygiene 0 0 3 2 7 0 9

	Decedent's Name (First, Middle, Last)		- 1	Certificate of	Deall	2. Date of De	Reg. No.	3 1	ime of Death
Physician						Month	Day	Year	526
/Medical	OLIVER J MILI				1	OCTOBE			200
Examiner	4a Facility Name (If not institution, give s					r Location of Deat			
	ST. AGNES HEALTHU	ARE 900	CATON	AVENUE	BALTI		BALTIMORE		
neral	5. Social Security Number 6. Sex		In yrs. last birt	hday) If Under 1 Y Months Da			th v. Year)	9. Birthplace ( Country)	State or Foreig
ctor	238-26-6795	\$M 2□ F	76	rs.		SEP 22	1924	NORTH C	
	Usual Residence of Decedent  10a. State 10b. County	11	Oc. City, Town	or Location				10d. In	side City Limits
Director	MARYALND BALTIN			LTIMORE					XYes 2□No
Director	10e. Street and Number	TORE	באם	10f. Zip Cod	1e		10g. Citizen of V	What Country?	
	Too. Stroot and Names					-		,	
Funeral	4005 COLBORNE ROA	AD 2. Was Decedent Eve	na in 11 C	212	of Hispanic Origin?	(Specify Vec or No	U.S.A.	e - American Inc	lian
5	The Market Orders	Armed Forces?	or iii 0,3.	If Yes, specify	Cuban, Mexican, Pue	nto Rican, etc.)		ck, White, etc.	,
bv F	1 Never Married 2 Married  3 Never Married 2 Married  3 Never Married 2 Divorced	tXXYes 2 ☐ No If Yes, Give Year or Dates:		1 □ Yes 2	No Specity:		Specify	BLACK	
			16a	Decedent's Usuei O	ccupation			usiness/industry	
Completed	(Specify only highest grade	completed)		(Give kind of work de life. DO NOT use re	one during most of watered)	orking		,	
JE C	Elementary/Secondary (0-12)	College (1-4or 5+)		LABORER			WINDOW	TREATME	ENT
Ö	17. Father's Name (First, Middle, Last)			BADORER	18. Mother's N	ame (First, Middle	, Maiden Surnan	10)	
Be	1.				len or				
2	unknown  19a. Informent's Name/Relationship (Type	ne Print)	19h	Mailing Address (St	unknow		er. City or Town.	State. Zip Code	)
	Juanita Brown/Sist			918 Allend Disposition (Name of		Date		City or Town, S	
	Burial 2 Cremation 3 R		cemeter	y, crematory or other	place)				
	4 Donation 5 Other (Specify)		GARR	ISON FORES		10-20-0	0 OWINGS	S MILLS,	MD
	21. Signature of Turneral Service License	1/2	,	22. Name and A	1 C BROWN	COMMUNTT	Y FUNERA	AL HOME	PA
	There Il.	(Men	ALL		NORTH AVE				
	23a. Part1. Enter the disease, or complication shock, or heart failure. List only on	al one that caused the	e death. Do r	ot enter the mode of	dying, such as cardi	ac or respiratory a	rrest,	Appr	oximate vai Between
an								Ons	at and Death
al	Immediate Cause (Finel disease or condition	my	10 cm	DIAC	INFAR	chon		/	hr
er	resulting in death) a	Du	e to (or as a o	consequence of):					
je l	THE REAL PROPERTY.			,					
Examiner	Sequentially list conditions.	. Du	e to (or as a c	consequence of):					
EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury								
CB	that initiated events resulting in death) Last	Du	e to (or as a c	onsequenca of):		3.42	-		
Medi									
Physician/M	d								
Physician/M	Part II. Other significant conditions con	tributing to death but r	not resulting in	the underlying caus	e given in Part I.	23b. Did	tobacco uss co	ntributs to the	cause of death
4d						10	Y88 2□ No	3 Probably	Unknow
þ									
Completed							s an autopsy ormed?	available	topsy findings prior to
Die								of death	ion of cause
- O						10	Yes 2 No	1 ☐ Yes	212NO
Be	25. Wes case referred to medical				26. Place of D	eeth (Check only	one)		
ToE	examiner?	ospital:	2 ER/Ou	tpatient 3 DOA	Other: 4 Nursing	Home 5 ☐ Res	idence 6 Oth	ner (Specify)	
2	27. Manner of Death	28a. Date of Injury (Month, Day Y		ime of 28c.	Injury at Work?	28d. Describe	how injury occur	rred	
atio	1 Netural 5 Pending investigation	(Worth, Day )	04/	M	1 ☐ Yes 2 ☐ No				
FIC	3 Suicide 6 Could not be determined	28e. Plece of Injury	- At home, fa	rm, street, factory, of	fice		(Street and Numi	ber or Rural Rou	te Number,
Certification:	- Individue	building, etc. (	opedity)			Ony or re	, Gluto/		
edical (	29a. Certifier Certifying Phys	ician: To the best of mer: On the besis of ex							
9	one)	and menner state	d.			1			
7	29b. Signature and title of certifier	1 -	(22)		cense number	10	29d. Date signe		
1	Male	UR.	10	4	00519	6)	Oc 706	722 1.	1 200
X	30. Name and address of person who con	mpleted cause of deat	th (item 23a) (	Type, Print)	717011111111		0070B		
1		EVETS		ST AG	NOS HOSO	-, THE	BATTI	mura	MD
State	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature		19.0				
gistrar	OCT 17 200	00	a product	6 1					
	12141 1 / /111	111111111111111111111111111111111111111	R. Sandand	19	and the same				

ORIGINAL

1121. A A



Piease Type or Print in Black Indelibie Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death Paul G. Mon October 13, 2000 9:00 AM 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 2711 Hemlock Avenue Baltimore N/A 5. Social Security Number If Undar 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Birthplaca (Stete or Foreign Country) Days Hours 1⊠M 2□ F Yrs. 220-14-3535 79 July 23, 1921 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Insida City Limits 1 Yes 2 □ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2711 Hemlock Avenue 21214 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Race - American Indian, Black, Whita, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Engineer Aerospace 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surneme) Alexander F. Mon Mary J. Osysko 19a. Informent's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Gregory Mon Sr./Son 901 Hackle Dr. Hampstead, Maryland 21074 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Ramoval from Stata 4 □ Donation 5 □ Other (Specify) Gardens of Faith 10/17/00 Baltimore, Maryland 21. Signature of Fuperal Service Licensee 22. Nama and Addrass of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 Do not anter the mode of dying, such as cerdiac or respiratory arrest, 23a. Fart 1. Enter the change or complete that the change in shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) CARDIOTHLMONARY Due to (or as a consequence of):

permit. Pages 1 and 2 should be filled within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than 'natural', or from 23a or 2 may injury or other traumatic event, the Medical Exercited and other traumatic event, the Medical Exercited and or other traumatic event, the Medical Exercited and other traumatic events. **Physician** /Medical Examiner il or Attending Physician: The lew requires that the death certificate be executed aftar death.

Birector: After this certificate hes been signed by the attending physicien end Box 68760. Division of Vital Records, P.O.

**Physician** 

/Medical

**Examiner** 

10a. State

MD

Director

by Funeral

Be Completed

**Funeral** 

Director

iene. r than "natural", or frems 23s or 28s-f show the Medical Examiner must be notified at

the Maryland

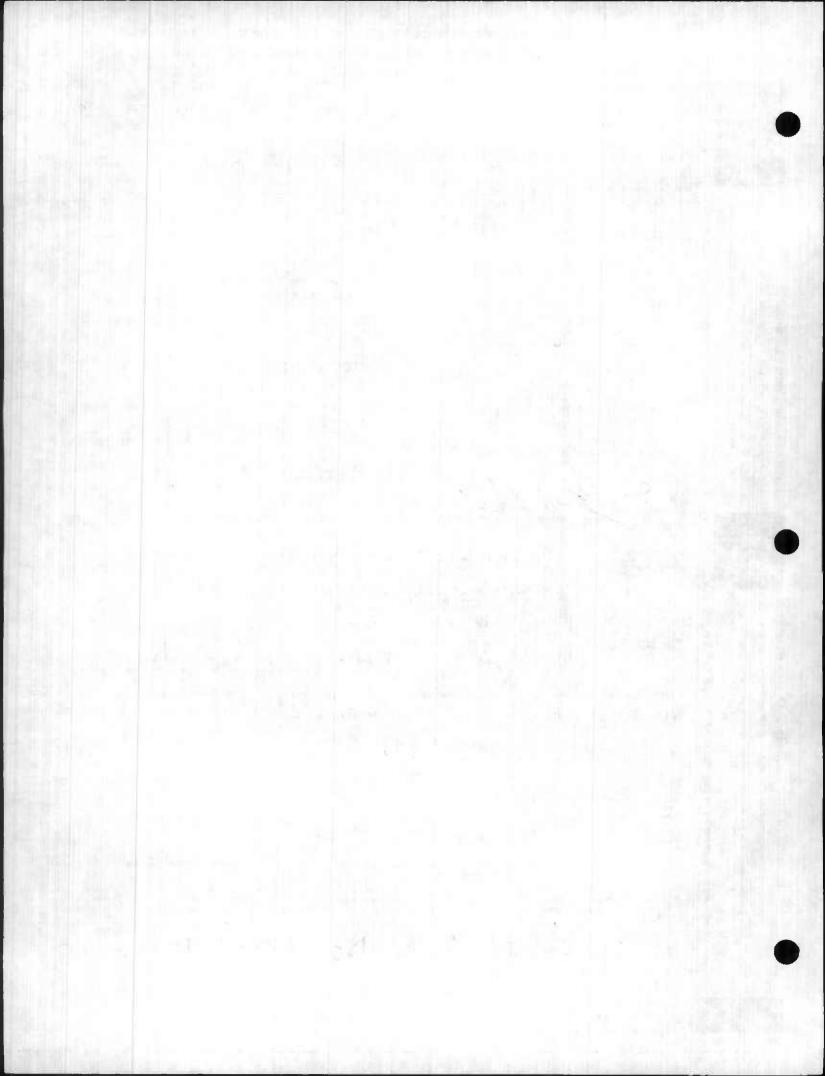
Baltimore, Maryland 21215-0020

Part II. Other significant conditions continued to the conditions conditions continued to the conditions continued to the conditions continued to the conditions continued to the conditions condition	Dua to (or as a consequence of):  CLINON ( DBSTEMC  ributing to death but not resulting in the underlying ceuse given in Par  LLION (WARTHELL	
		24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of causa of death?
25. Was cese referred to medical	26 Pia	ace of Deeth (Check only one)
examiner 1 H	ospital: Other	Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
7. Menner of Death 1 Deltaturel 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Work? Injury M 1 ☐ Yes 2 [	28d. Describe how injury occurred  □ No
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rurel Route Number, City or Town, State)
	ician: To the best of my knowledge, death occurred at the time, date are: On the basis of examination and/or investigation, in my opinion, deand manner stated.	
96. Signature and title of certifier	29c. Licansa numbe	29d. Date styned (Month, Pey, Year)

**DHMH 16 Rev 6/95** 

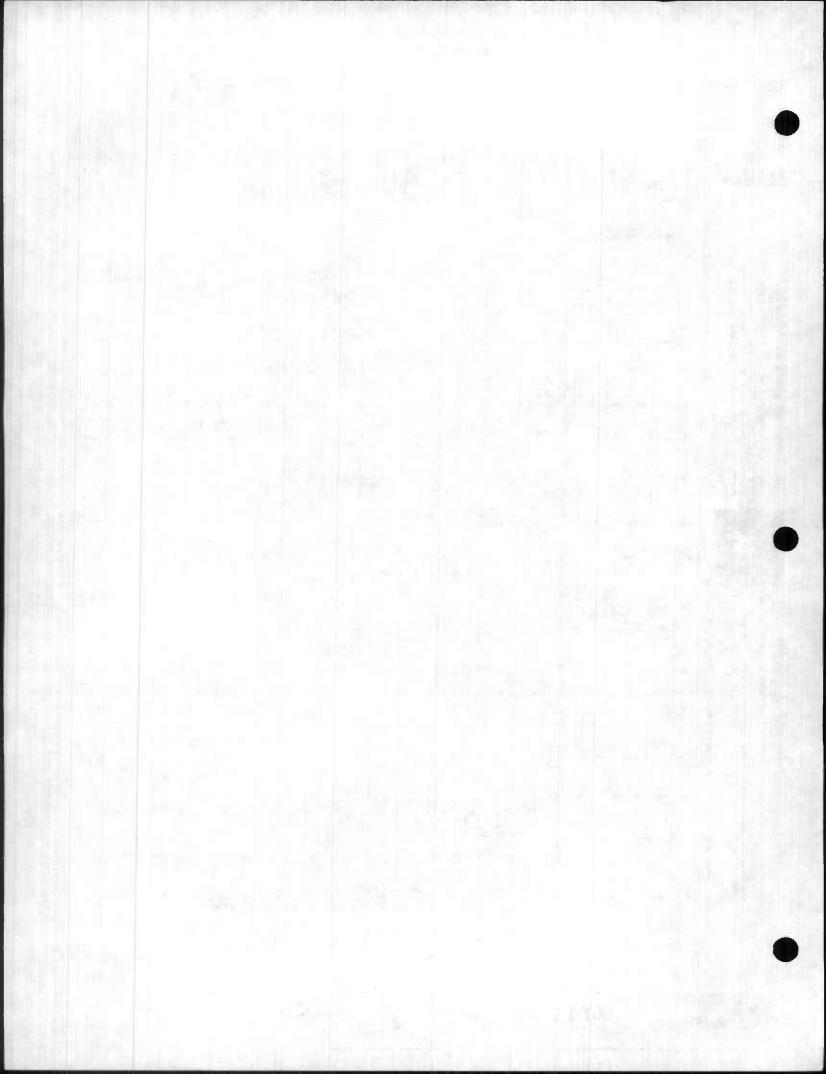
State Registrar

31. Date filed (Mont)



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 2 7

						Cer	tificate of	Death		Reg. I	No.					
	Dhualala	-	1. Decedent's Nama (First, Middla, La			-511			2. Date of Month		Day	Yaar	3. Tima of Death			
	Physicia: /Medica	il .		es Phillip	Nilan				OCT :	15, 2	2000		10:20am			
	Examine		4e Facility Nama (If not Institution, git						, or Location of De	ath	c. County o	f Death				
_			8 North Southwood		/la bat	hinth day ()	If Under 1 Year		Apolis Hrs. 8. Date of	Diel			rundel			
	Funeral Director		5. Sociel Security Number  101-28-8636  Usual Rasidanca of Decedant	Sax 1M 2□ F	(In yrs. last	Yrs.	Months Days		Min. (Month,	Day, Yea			leca (Stata or Foreign try) Virginia			
	Mand		10a. Stata 10b. County		10c. City, To	own or Loc	ation					10	0d. Inside City Limits			
	Mar	20	Maryland Anne A	rundel		Aı	nnapolis	5					1 ¥ Yas 2 No			
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. (	Citizen of Wi	hat Count	try?			
	23a	00	8 North Southwo				21401				USA					
21215-0020	e sun	by Fur	11. Maritel Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedant E Armed Forcas? 1 Yas 2 N If Yas, Giva Yaar or Datas:		-	/es Decedent of Yas, specify Cut ☐ Yes 2X No		7 (Specify Yas or Puerto Rican, etc.)	No-	14. Raca Black Specify:	, Whita, a				
5-0	72 ho	Completed	15. Decedent's E		10	6a. Deced	ant's Usual Occu	pation during most o	f working	16b.	Kind of Bus	usiness/Industry				
12	within ene. then "	de l	Elemantery/Secondary (0-12)	Collega (1-4or 5-	+)		ind of work done O NOT usa ratin	ed)								
	il Hygiene. other then		17. Fathar's Nama (First, Middla, Last	4		Own	er	18 Mother's	Name (First, Mid		Small		ness			
and	SED C	0 0	Charles Phill									,				
Maryland	should bend Mented is marked	-	19a. Informant's Name/Ralationship		othy Helen Flynn  Rural Routa Number, City or Town, State, Zip Code)											
Z	old 2 stranger trans		Lisa Stahr/wife						renue Ar							
re,	of Hee		20a. Method of Disposition		20b. Place	of Dispos	ition (Nema of etory or other pla	aca)	Data	20c.	Location - C	ity or To	wn, Stata			
E	ent ent rt: II		1 Buriel 2 Dramation 3 C				ematory,		10/16	00	Balti	more	. MD			
Baitimore,	Department Department Important: any injury		21. Signature of Funeral Service Lice	9400 ma-1					tra of M		Т.					
Ω	88 5 5 8		21. Signature Funeral Service Communication Society of Maryland, Inc. 22. Nama and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228													
	Physician		23a. Part1. Entar tha disaasa, or com shock, or haart failura. List only	plications that caused one cause on each lin	tha death. De.	Do not ente	r the mode of dy				+ 00		Approximata Interval Batween Onsat and Death			
	/Medical Examiner	ner	Immediata Ceuse (Final diseasa or condition resulting in death)	a. Prime	Qua to (or)as	a consaqu	uenca of):	Can	cert t	epa	ice v	lular	5 Months			
68760,		Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated avants  Due to (or as a consequence of):  Due to (or as a consequence of):														
Box 687	5 08	Dev	rasulting in death) Last	d	Due to (or as	e consequ	rence of):									
m.	atte atte		Pert II. Other eignificant conditions	contributing to death bu	t not resultin	o in the un	deriving cause g	ivan in Part I.	23b. [	old tobac	co uee con	tribute to	the cause of death?			
s, P.O	5 60	by Physicians								□ Y••	-	3 Prot				
Records	hes been sign be 2 should be	Completed							24a. V	/as an eu erformed	itopsy	COL	are autopsy findings alleble prior to mplation of causa death?			
œ	The Lats he page	5							1	☐ Yas	2 XNo	10	Yes 20 No			
Vital	centificata rector, pag	-	25. Was casa rafarred to medical axaminer?						Deeth (Check or	lly one)						
of V	d sig	0	1 ☐ Yas 2 No	Hospital: 1 Inpatier		/Outpatient	3LI DOA		ing Home 5XR				v)			
n o	After t	0	27. Mennar of Deeth  1 Natural 5 ☐ Pending	28a. Data of Injury (Month, Day	Year) 28	b. Tima of Injury		ork?	300,000	be how in	njury occurre	ed				
Division	after death. Director: After 3 in by the fune	Certification:	Accident Investigation    Suicide   Could not be determined	00 - 51(1		, farm, stre		]Yas 2□No	28f. Location	n (Street Town, St	and Numbe ata)	or or Rura	I Routa Number,			
_	Hospi 24 hours Funer tely fil		29a. Certifier (Check only one)  Certifying Properties one)	nyelcian: To the best of miner: On the basis of and mannar stat	examination	dge, deeth and/or inv	occurred at the testigation, in my	lime, date and popinion, death	place, and due to occurred at the tir	tha ceuse na, data a	a(s) and mar and placa, a	nner as st	ated. the cause(s)			
	Within 2 the comple	2	29b. Signetura and titla of cartiflar				29c. Licar	nsa number	Manager 2	29d.	Data signed	(Month,	Dey, Year)			
			March (	nother (	(0.4	0	DI	4611	8	no	+ 16	. 2	2000			
	0		30. Nama and addrass of person who	complated causa of da	ath (Item 23	a) (Type, F	Print)	TNII			-1 18	10				
	6		JANET COOP	ERMO	1447	· Yo	RKRA	Lute	emille	M	0 2	100	13			
	State Registra	7	31. Date filed (Month, Dey, Year) OCT 1	7 2000 N	Signatura	w A	& fo	acks			- 4					



State of Maryland / Department of Health and Mental Hygiene 00 32712

	Certificate of D	Death Reg. No.
Physician	1. Decedent's Nema (First, Middle, Last)	2. Deta of Death Month Dex Year  3. Time of Death
/Medical	Eileen M. Newsome	October 13, 2000   6:20 AM
xaminer	4a Facility Name (If not institution, give street end number) Holy Cross Hospital	c. City, Town, or Location of Death Silver Spring  4c. County of Death Montgomery
neral ector	5. Social Security Number 388-22-9366 6. Sex 1 M 2CKF 7. Aga (In yrs. last birthday) 1 Months Days 75 Yrs.	tf Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 8/2/1925 9. Birthplaca (Stete or Foreign Country) Wisconson
	Uauel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
rector	MD Montgomery Silver Spring	1 □ Yes 2 □ No
90	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
Funeral Director	924 Patton Drive 20901	U.S.A.
by	11. Meritel Status  1 □ Never Merried 2 □ Married  3 ☑ Wildowed 4 □ Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Yes 2 ☑ No  1 □ Yes 2 ☒ No  1 □ Yes 2 ☒ No	spanic Origin? (Specify Yas or No., Mexican, Puerto Rican, etc.)  14. Race - American Indien, Black, White, etc.  Specify: White
eted	15. Decedent's Education 16a. Decedent's Usual Occupal (Specify only highest grade completed) (Give kind of work done du	tion 16b. Kind of Business/Industry
Completed	(Specify only highest grade completed)  Elementery/Secondary (0-12)  12  (Give kind of work done do life. DO NOT use retired)  Homemaker	Own Home
ပိ		18. Mothar's Nama (First, Middle, Maiden Surnama)
To Be C	Otto Beining	Unknown
-	19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street au	nd Number or Rural Route Number, City or Town, State, Zip Code)
To	Steve Newsome/Son 924 Patton Dr	rive Silver Spring, Maryland 20901
	20a. Mathod of Disposition  20b. Place of Disposition (Name of cemetery, cremetory or other place	Date 20c. Location - City or Town, Steta
6	1 X BURAL 2 L Cremation 3 L Hemovel from State	netery 10/18/00 Baltimore, Maryland
any injury once.	21. Signature of Euneral Service Licenses 22. Nama end Addrass 6415 Belair	s of Facility John C. Miller inc. Road Baltimore, Maryland 21206
	23a. Pert1. Enter the disease, or complications that caused the death. Do not entar the moda of dying shock, or heart failure. List only one cause on each line.	
s the bunishment and leading the bunishment and	Immediate Causa (Final disease or condition resulting in death)  a. Arrhythmia  Dua to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.	
an/Medical	cause (crisease of injury that initiated events reaulting in death) Last  Due to (or as e consequence of):	
sicia	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given	n in Pert I. 23b. Did tobacco use contribute to the cause of death?
by Physician/	Diabetes Mellitus, Recurrent	1 Yee 25 No 3 Probably 4 Unknown
2 should pleted	Pneumonia	24e. Waa an autopsy performed?  24b. Were autopsy findings evailable prior to completion of causa of death?
Com		1 ☐ Yas 2 🗖 No 1 ☐ Yas 2 ☐ No
B B	examinar	26. Place of Death (Check only ona)
78	1 Ves 2 No Hospital: 1 Inpatient 2 RF/Outpatient 3 DOA Other	4 Nursing Home 5 Hasidence 8 Dotner (Specify)
Campletely filled in by the funeral Medical Certification:	2 Suiside 6 Could not be	as 2 □ No
ed in by	determined  28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
edical	29e. Certifiar (Check only one)  1 ☐ Certifying Physician: To tha best of my knowledge, death occurred et the tima (Check only one)  1 ☐ Certifying Physician: To tha best of my knowledge, death occurred et the tima (Check only one)	a, data and place, and due to tha cause(s) and manner as stated.  inion, deeth occurred et the time, date end plece, and dua to the cause(s)
E X	29b. Signatura and titla of centifier	
	D4:	2518 10/13/00
11	30. Nama and address of person who complated cause of death (Itam 23a) (Type, Print)	
/	Gul Chablani MD 11119 Rockville PK #316 1	Rockville Maryland 20852
State	Gul Chablani MD. 11119 Rockville PK. #316 1 31. Dete filed (Month, Day, Year) 32. Registrer's Signetura	MUCHVIIIE, Maryland 20052



Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#23a perPHY3788 10 17/2000 EW Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth 6th **Physician** PENNICK HERMAN OCTOBER 2000 2.48 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner GOOD SAMALITAN HOSPITAL BALTIMOKE NIA If Under 24 Hrs. 8. Dete of Birth (Month, Dey, If Under 1 Year 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthdey) 9. Birthpiace (State or Foreign Country) **Funeral** Months Days 7.5 Yrs. 149-16-7616 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No MARYLAND Director 238-7 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6116 20 KOAD USA. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No 14. Raca - American Indian. 11. Meritel Stetus Black, White, etc. 1 Never Married 2 Married 8 1 Yes 2 No Specify: Yes. Give Àq 3 Widowed 4 □ Divorced BLACK Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OFFGRADE PARKS & RECREATION GROUNDS MEN Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) should be fil and Mental H a marked oth GEORGE STELLE and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an 12N ROSEDALE AVE. BALTO, MD. 21216 Item 27 SON. KEITH 20a. Method of Disposition

10 Burial 2 Cremation 3 Removel from State Place of Disposition (Name of cametery, cremetory or other piece) 20c. Location - City or Town, Stete ARBUTUS CEMETERY 10-11-00 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

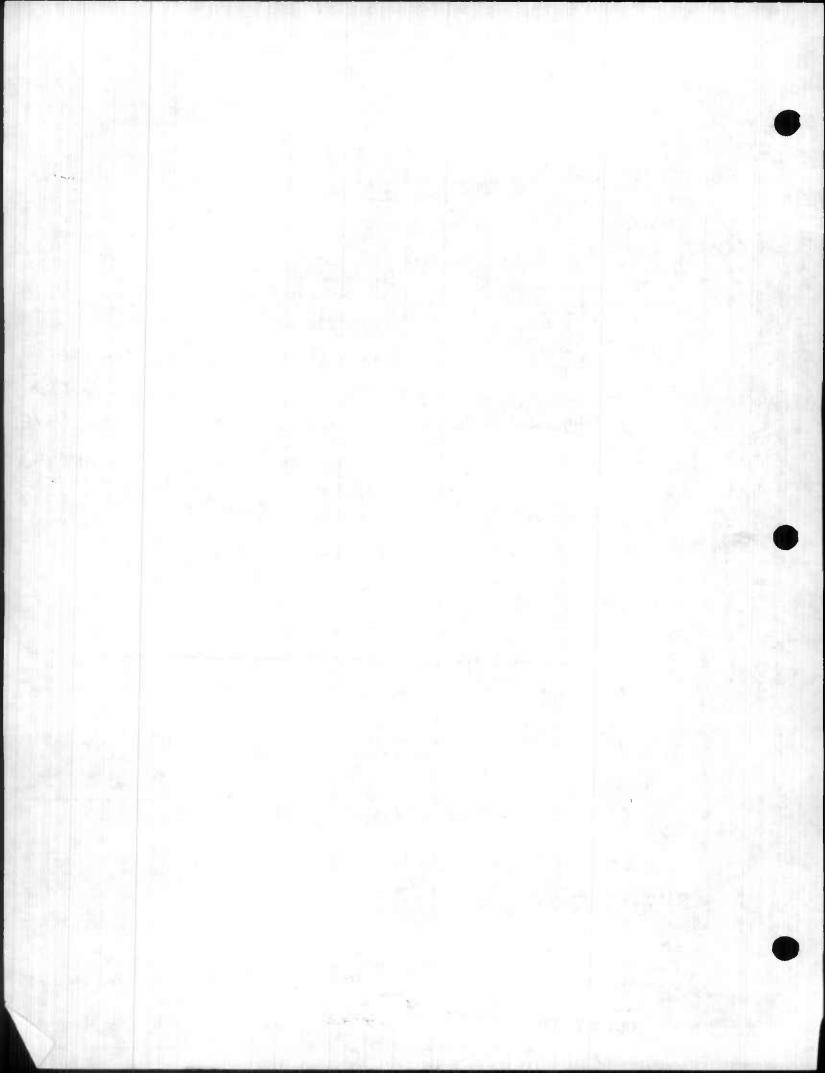
22. Name and Address of Facility

BROWN JR. FUNER

BALTIMORE

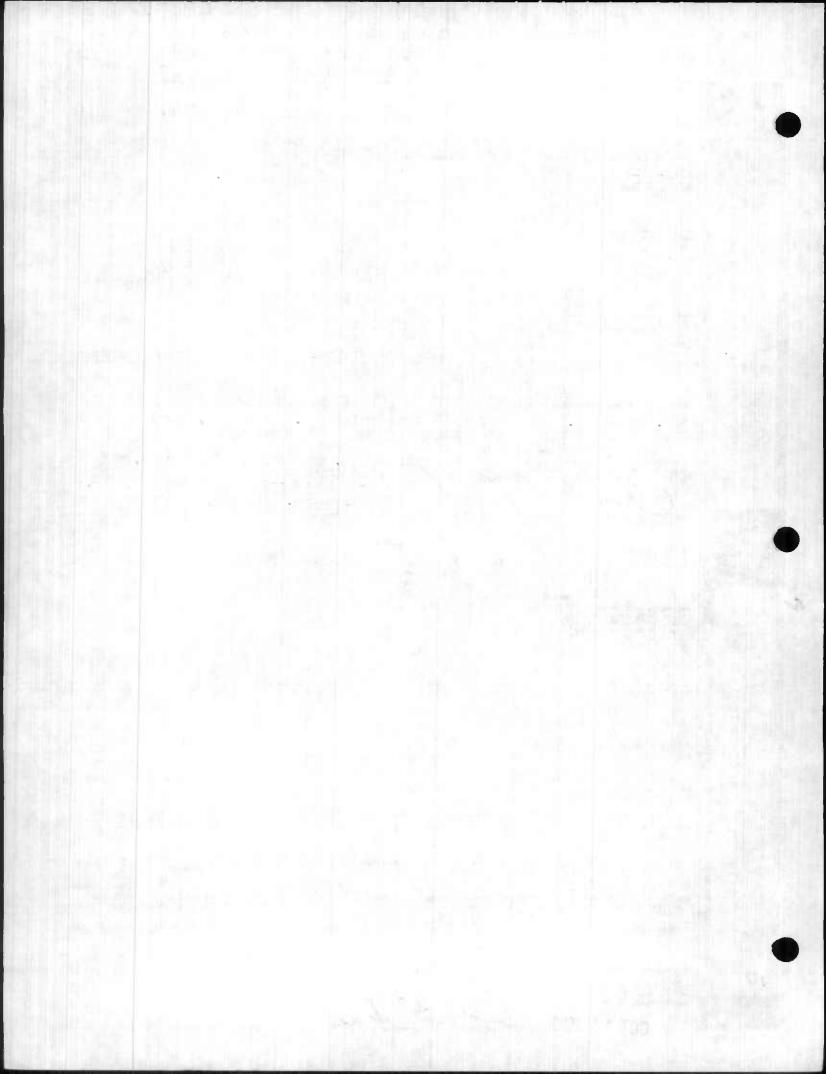
Do not enter the mode of dying, such as cardiac or respiratory arrest. of Furteral Service Liqu BROWN JR. FUNERAL À 23a. Part1. Enter the disease, or complications that caused the death shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical MYOCARDIAL INFARCTION Liamine Due to (or es e consequence of): Physician/Medical Examiner METASTATIC CARCINOMA OF THE PROSTATE The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760. Due to (or as a consequenca of): FTASTATIC P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? Medical Certification: To Be Completed 24a. Was an autopsy performed? 1 Ves 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes case referred to medical 26. Piece of Death (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours a To the Funeral D To the Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner steted. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 13457 ara MBBS OCT. 06,2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ROSEMAN & MARKS TO COOD SAMARITAN HOSPITAL 560 ( COCH RIVEN BUD, BALT MO 21239 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State Registrar OCT 1 7 2000 **DHMH 16 Rev 6/95** 



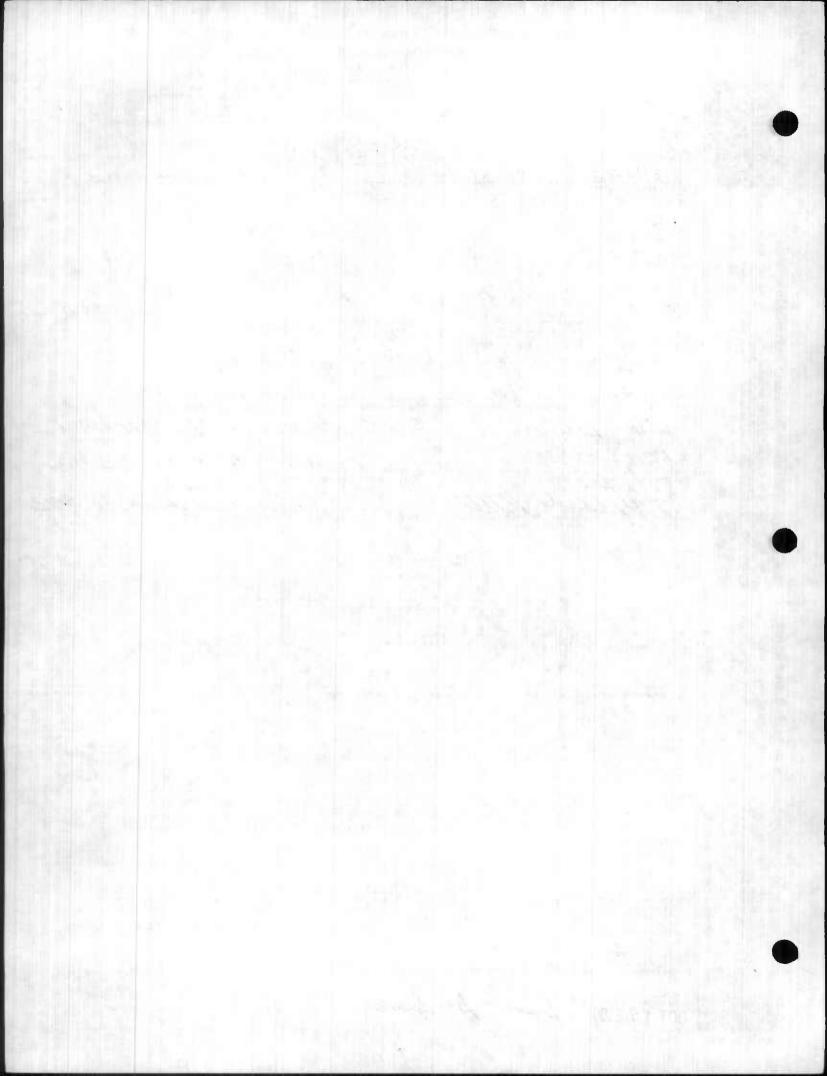
State of Maryland / Department of Health and Mental Hygiene 0 0 327 14

	Certific	ate of Death	Reg	i. No.	2114
District Control	Decedent's Neme (First, Middle, Last)		2. Date of Death Month Dey Year		3. Time of Death
Physician /Medical	Stephen Barry Prat	t		15,2000	1:20 AM
Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or L	ocation of Death	4c. County of Deeth	
	Atlantic General Hospital Berlin Worcester				
Funeral Director	5. Social Security Number  6. Sex  7. Age (In yrs. last birthday) 42 Yrs.  7. Age (In yrs. last birthday) 42 Yrs.  1. Age (In yrs. last birthday) 42 Yrs.  2. Age (In yrs. last birthday) 42 Yrs.  3. Date of Birth (Month, Day, Year) 43 Jan. 30,1958  44 Arryland				
pu au	Usuel Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location			1	IOd. Inside City Limits
Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hydjene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at page.  To Be Completed by Funeral Director	Maryland N/A	Baltimore		Chi-	1 ☐ Yes 2 ҈No
	10e. Street and Number  3903 Foster Avenue  10f. Zip Code  10g. Citizen of What Country?  United States				
	1 Never Married 2 Married 1 Yes 25 No	ecedent of Hispanic Origin? (Specify Cuben, Mexican, Puerto as 202No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Americ Black, White, Specify:	
	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind of Give kind of Gi	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			
	Elementery/Secondary (0-12) College (1-4or 5+)	Truck Driver Trucking Industry			
	17. Fether's Name (First, Middle, Last)		ne (First, Middle, Ma		
	Curtis Owen Pratt Jessie Luella Smith				
	19e. Informant's Neme/Reletionship (Type, Print)  19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)  Mrs. Barbara A. Pratt (Wife)  3903 Foster Ave. Baltimore, Maryland 21224				
	20a. Method of Disposition  1  Buriel 2  Cremation 3  Removal from State  4  Donation 5  Other (Specify)  20b. Placa of Disposition (Name of cemetery, crematory or other place)  Meadowridge Mem. Park 10/19/2000  Dorsey, Maryland				
Balt Departi Importa any Inju	21. Signature of August Service Licensee  22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222				
	23e. Pant. Enter the disease, or complications that an and be death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each light			Approximete Interval Between	
Physician (Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Onset and Death  Onset and Death				
of Vital Records, P.O. Box 68760, Physician: The law requires that the death certificate be executed this certificate has been signed by the ettending physician and real director, page 2 should be deteched for use as the bunal-transit. TO Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequenca of):				
	d				
	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.		23b. Did tobacce tias contributs to the cause of death?		
			1 No 3 Probably 4 Unknown		
			24a. Wes an performe	ed? ev	fere eutopsy findings vailable prior to empletion of cause death?
			1 ☐ Yes	200 No 1	Yes 2 No
	25. Was case referred to addical examiner?				
	Hospital: 1 Inpatient 2 FROutpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)				
After fune					
C State	3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, fa building, etc. (Specify)	, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)			al Route Number,
To the Hospital Within 24 hours To the Funeral completely filled Medical Co	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner es stated.  2 Medical Examiner: On the basis of Samination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and menner stated.				
To the complex complex Me	29b. Signature end title of certifie				
	19108 1011610				
David Schart, www 808 S. Concling St. Bolt, MD 21224					
State Registrar	31. Date filed (Month, Day, Year) 32. Registrer's Signature	200			



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) **Physician** 16 2000 Cto /Medical 4b. City, 4c. County of Deet 4e Fecility Name (II pet institution, giva stree **Examiner** MUNder 24 Hrs. Jo D. 9. Birthplaca (Stata or Foraign Country) Social Security Number 6. Sax 7. Aga (In yrs. last birthgay) 8. Dete of Birth (Month, Day, Year) Deys 10M 20F Yrs. 212-14-8686 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or flams 23s or 28s-f show traumstic avant, the Medical Examiner must be notified at md 1 Nos 2 No Director 15A 1TO 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? 21213 2025 VALE ST Funeral Pages 1 and 2 should be filed within 72 hours effer death nent of Health end Mentel Hygiene. nnt: If item 27 Ia marked other then "natural", or Itema 23 11. Marital Status Was Dacedent Evar in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No If Yes, Give Yeer or Detes: Saltimore, Maryland 21215-0020 1 Yes 2 No by AR 3 Widowed 4 □ Divorced Be Completed 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary, (0-12) College (1-4or 5+) School 12 Grad & 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Surnama) JOXANNA 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health e Important: If Itam 27 la any Injury or other training once. Sous senlor 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stete Date Burial 2 Cremetion 3 Removel from Stete
Donetion 5 Other (Specify) 45 22. Name end Address of Fecility 2/3/ 10.mg reoline 23a Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. **Annroximate** Intarval Batween Onset end Deeth **Physician** tmmediate Ceuse (Final disaasa or condition rasulting in deeth) /Medical UNKNOWN Examiner Due to (or as e consequenca of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): The law requires that the death certificate be execu Box 68760. Dua to (or as a consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Medical Certification: To Be Completed by 24b. Were eutopsy findings evailable prior to completion of cause of death? page 2 should 24e. Wes en eutopsy performed? After this certificate has 2 00 NO 1 Yes 200 No 1 Yes To the Hospital or Attanding Physician: 25. Wes case referred to medical axaminer? 26. Piace of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending invastigetion s after death. 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide To the Funeral Diracto 28e. Placa of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) end manner steted 29c. License number 29d. Dete signed (Month, Day, Year) Saleaver 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNS HOP JASTASIOS SALIARIS HOPKINS HOSPITAL, TOWER 110, BALTIMORE MD OCT 1 7 2000 State Registrar



State of Maryland / Department of Health and Mental Hygiene

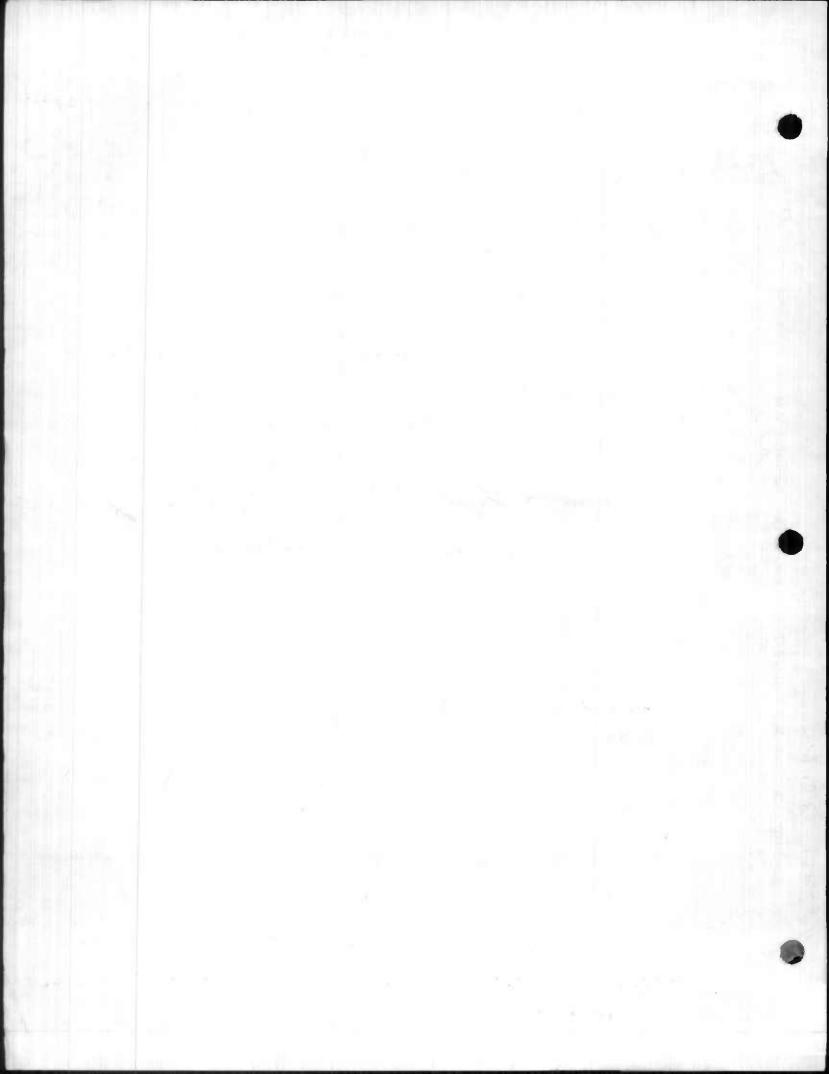
Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** Month Yaar 9:27 AM DCTOBER 16 ROBERT DANIEL PFEIFFER, JR. 2003 /Medical 4a. Facility Nama (If not Institution, give street and number) 4h City Town or Location of Death 4c. County of Daath Examiner 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. EASTPOINT NURSING HOME BALTIMORE 5. Social Sacurity Number Birthplaca (Stata or Foreign Country) 8. Data of Birth (Month, Day, Yaar) **Funeral** Director 219-18-7245 Oct. 30.1924 MARYLAND Usual Rasidanca of Dacedan 10a Stata 10h County 10c. City. Town or Location 10d. Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Haaith and Mental Hygiena. Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show any Injury or other traumstic event, the Medical Examine must be notified at 1 X Yas 2 □ No Director MD. N/A BALTIMORE 10e, Straat and Number 10f. Zip Code 10g. Citizan of What Country? 225 S. WASHINGTON STREET U.S.A. 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, atc. Amed Folds.

1 M Yas 2 No
If Yas, Giva
Yaar or Datas: 1943-46 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorcad WHITE 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 10 SUPERVISOR CARR-LOWREY GLASS 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be RUBERT D. PFEIFFER, SR. FLORENCE E. RITTER 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat end Number or Rural Routa Numbar, City or Town, Steta, Zip Coda) NANCY PFEIFFER/ WIFE 225 S. WASHINGTON STREET, BALTIMORE, MARYLAND 21231 20b. Placa of Disposition (Nama of cemetary, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Crametion 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) BALTIMORE NAT'L CEM. 10/19/00 BALTIMORE, MARYLAND 21. Signatura of Funaral Sarvica Licansaa 22. Nama and Addrass of Facility LILLY & ZEILER INC. FUNERAL HOME 23a. Part1. Entar tha diseasa, or complications that causad tha death. Do not antar tha mode of dylng, such as cardiac or faspiratory arrast,

Approximate

Approximate Approximata Interval Batween Onsat and Death Physician Accodent /Medical Immediata Cause (Final (erebrovascular disaasa or condition rasulting in daath) Examiner sicien and buriel-transit Saquantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Diseasa or Injury that Initiated avants rasulting in daath) Last Dua to (or as a consequance of): physicien s the buriel Physician/Medicai Dua to (or as a consequence of) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 00 CANCER 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to complation of cause of death? CAD Completed 24a. Was an autopsy performed? 25. Was casa referred to medical 26. Placa of Death (Check only ona) axaminer? 1 ☐ Yas 2 No Othar: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 2 1 | Inpatiant 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury et Work? 28d. Dascribe how Injury occurred Certification: 5 Pending Invastigation 1 Naturel death. 1 ☐ Yas 2 ☐ No after death 2 Accidant 6 Could not be detarmined 3 ☐ Suicida 28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) P 4 Homicide To the Hospital o within 24 hours af To the Funeral DI completally filled is edicai 29a. Certifian 12 Cartifying Physician: To the bast of my knowladga, death occurred et the time, data and placa, and due to the ceuse(s) end mannar as stated.
2 Medical Examiner: On the basts of exemination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. (Check only one) 29b. Signatura and titla of cartifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) D45757 16,2000 30. Nema and addrass of person who completed causa of deeth (Itam 23a) (Type, Print) MATTHEW MONASNET 5505 HOPICINS BAYVIEW UND BAC ZIZY 31. Data fliad (Month, Day, Year) 32. Ragistrar's Signatura State Registrar OCT 1 6

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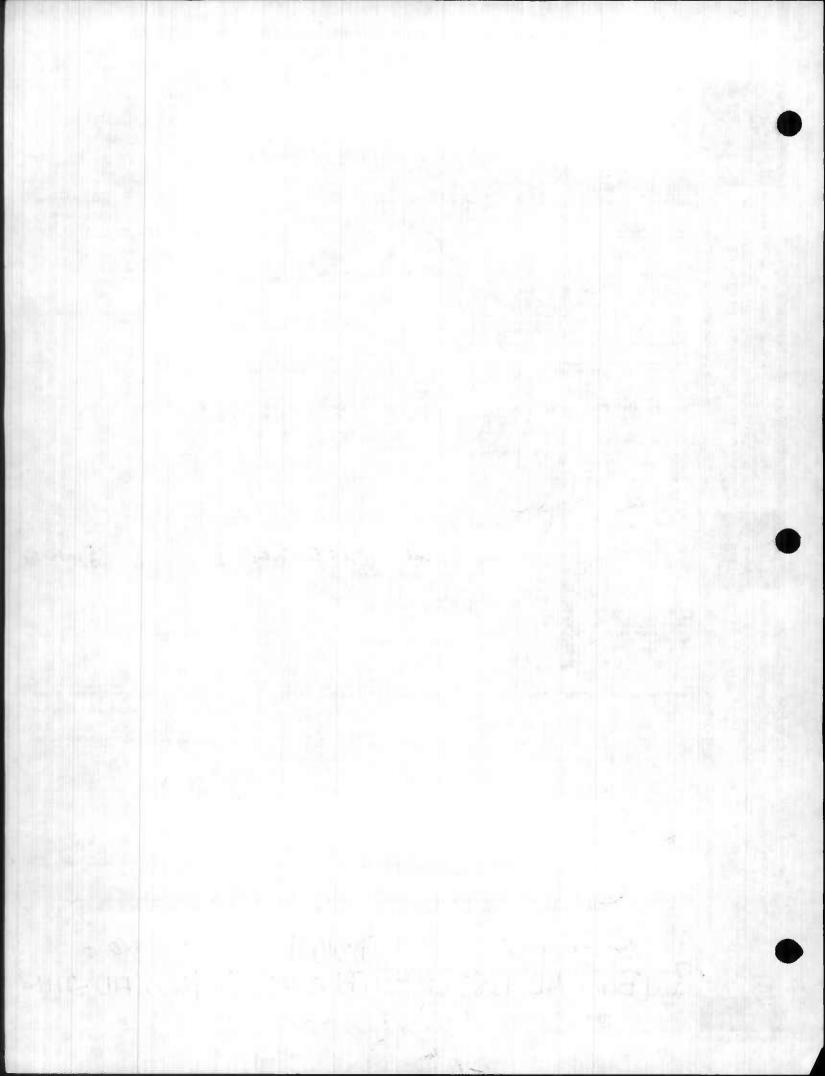
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/	Depa	artme	ent	01	Hea	alth	and	mental	Hygiene
	_								

	Certificate of Death		g. No.	32717							
Physician	1. Decedent's Neme (First, Middle, Last)	2. Dete of Deeth Month	Dey Y	3. Tima of Death							
/Medical	CECTL BETHLEHAM RAGSDALE  4e Facility Name (If not institution, give street and number)  4b. City, Town, or Lo	OCTOBER	4c. County of	00							
Examiner	ANNAPOLIS REHABILITATION CENTER ANNAPOLIS ANNE ARUND										
Funeral Director	5. Social Security Number 217-24-4549 6. Sex 70 Yrs. Security Number 7. Age (In yrs. last birthdey) 1. Months Deys Hours Min.	Year) 9	Birthplece (Stete or Foreign Country)  MARYLAND								
2	Usual Residence of Decedenf		7, 1523								
show of a	10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2X No							
with the Mar or 28e-1 si be notified Director	MARYLAND ANNE ARUNDEL CROWNSVILLE  10e. Street and Number 10f. Zip Code	10	On Citizen of Wha	f What Country?							
death with the Manyland one 23a or 28e4 show constitute be notified at neral Director	1090 PLUM CREEK DRIVE 21032		U.S.A.								
5 22 5	11. Meritel Status  1	ecify Yes or No- Rican, etc.)	American Indian, Whita, atc. WHITE								
	15. Decedent's Education (Specify only highest grede completed)  Elementery/Secondary (0-12)  12  16a. Decedent's Usual Occupation (Give kind of work done during most of works) (iffe. DO NOT use retired)  REFUSE REMOVAL	ing 1	SANIT								
yland 212 ould be filed within Mental hygiene.  riked other than with event, the M	17. Father's Nema (First, Middle, Last)  CECIL B. RAGSDALE MYRTLE	(First, Middle, M	faiden Sumeme)	R							
Maryland of 2 should be file the and Mental Hy if is marked other traumatic event To Be (	19a. Informent's Neme/Reletionship (Type, Print) DAVID RAGSDALE (SON)  19b. Meiling Address (Street end Number or Rura 1090 PLUM CREEK DRIVE,										
Baltimore, emit. Papes 1 ar Neparlment of Hea montant: If Hean 2 my Injury or other bace.		0/16/200									
Baltim permit. Pa Departmen Important: any injury ands.	21. Shoratare of Fourial Service Locasee 22. Name and Address of Facility SING 1 SECOND AVENUE, S.1	GLETON F		HOME, P.A.,							
Physician	23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock or heart failure. List only one cause on each line.	or respiretory erre	est,	Approximete Intervel Between Onset and Deeth							
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aw requir		24a. Wes er perform		24b. Were autopsy findings available prior to completion of cause of daeth?							
- 6 a a		1 □ Ye	s ZENO	1 ☐ Yes 2 ☐ No							
Of Vital Re Physician: The I this certificate he rel director, page	25. Wes case referred to medical exeminer?  Check A. C. Plece of Deetle exeminer?										
Of Vita Physician: this certific ral director,		me 5 Reside									
Sion leading leath. for: Aher the fune cation	1 Natural 5 Pending (Month, Dey Year) Injury Work? 2 Accident Investigation M 1 Yes 2 No	200. 0030100 110	w injury occurred								
Or A she of	20 Suitaida 60 Could not be	28f. Location (Str City or Town		or Rural Routa Number,							
Cal Cal	Cartifying Physicien: To the best of my knowledge, death occurred et the time, data and place, and best of exemination end/or investigation, in my opinion, deeth occurred end manner stated.	and dua to tha ca ed at tha time, da	usa(s) and mann ata and placa, end	ner as stated. d due to the cause(s)							
To the H within 24 To the F Complete	296. Signature and the of certifier 29c. Licanse number 329.	29	9d. Date signed (1	Month, Day, Year)							
30	Parent Burez, MO 1655 Crotton Blvd #01	Crot	ton,	MD 21114							
State	31. Date filed (Month, Dey, Year) 32. Registrer's Signature										

DHMH 16 Rev 6/95

Registrar

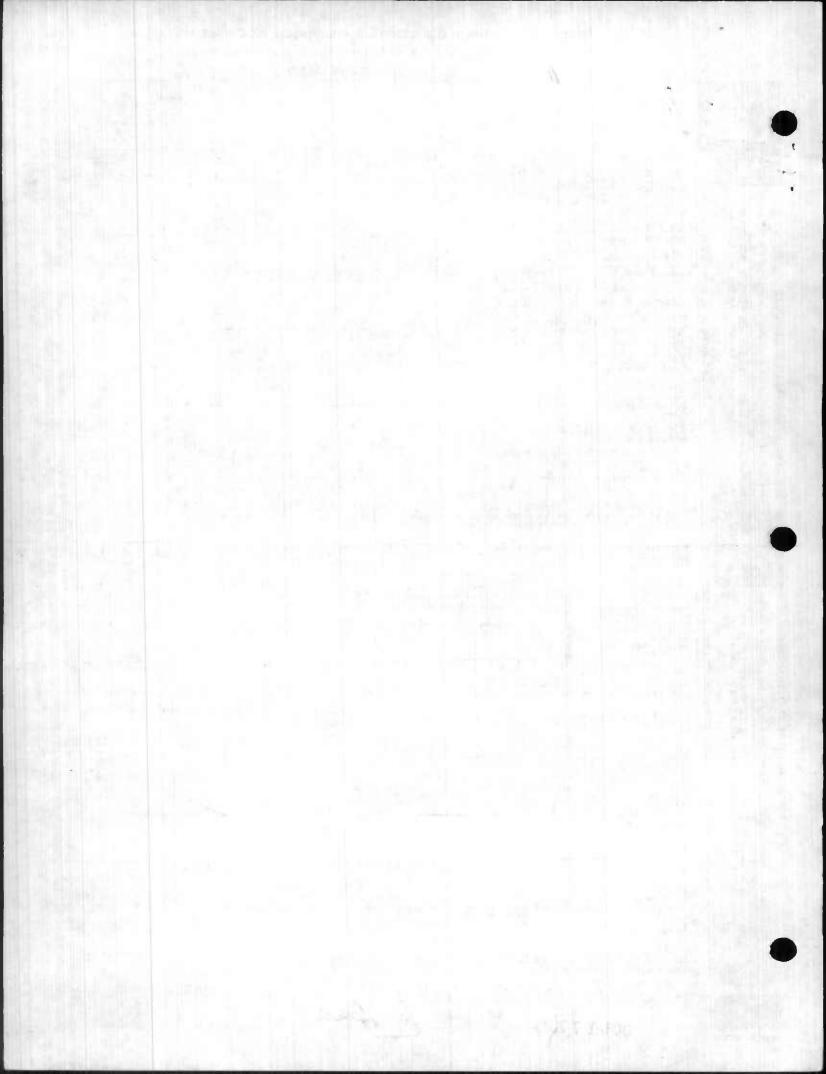


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. AMEND#23C&D &#27 PER MD. G789 11-2-2000 JAB Department of Health and Mental Hygiene Amended Item#26 perPHYG788 10/17/2000 EW Certificate of Death 1. Decedent'e Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** MATTIE KOSE BORDUGH SEPT. 2000 /Medical 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street end number) 4c. County of Death Examiner W. BELVEDERE 3800 BALHMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Coupty)
5-CANO Line 7. Age (In yrs. lest birthdey) 10 M 20F Months Deys Hours Min 218 22 1730 Director Usuel Residence of Decedent 10a, Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits LEVES 2 No BOLLINOK Directo Marylon 10a. Street and Number 1006 10f. Zip Code 10g. Citizen of Whet Country? 23a or BELUED EVE W 3800 USB 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien. 11. Meritel Stetus Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 □ Never Merried 2 □ Merried Maryland 21215-0020 1 ☐ Yes 2 ☐No Specify. Specify: Black ğ 3 Nidowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent'e Education (Specify only highest grede completed) Private family Elementery/Secondary (0-12) College (1-4or 5+) Domestic 9 rade 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) WILLIAM TORRENCE EMMA 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) VANITA ROSEBURUUGh Mortimen Ave Merry Ins Boltwer If Health. Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 Burial 2 Cremetion 3 Removel from State 4 Donetlon 5 Other (Specify) important: I any Injury o ance. BAITHER, 22. Neme end Address of Fecility CAATM M 21. Signeture of Funeral Service Licensee 52 40 REISTERSTUMN NORD 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) RD BURSUL MY Examiner Due to (or es e consequence of) Physician/Medical Examiner type-(ipipemin Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Box 68760. CATINO Due to (or es e consequence of): NUTTINOPAL P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown pergens on à Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of deeth? To the Hospital or Attending Physician: The law require within 24 hours after feath.

To the Fundral Director. After this certificate has been si completely filed in by the funeral director, page 2 should 24e. Wes an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Be 25. Wes cese referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient — 2 ☐ TVOutpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Yes 2 No 27. Manner of Deeth 28d. Describe how injury occurred Injury et Work? 1 Neturel 5 Pending 1 Yes 2 No 2 Accident investigation 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end menner steted. 29a. Certifier 29c. License number 29b. Signature end title of certifier 29d. Dete signed (Month, Day, Year) now 200475 MD 00 mpleted cause of deeth (Item 23e) (Type, Print) 30. Neme and address of person who JOSE M. 31. Dete filed (Month, Day, Year) 420 DATTERSON BAU, MD ZIZB 32. Registrer's Signeture State Registrar OCT 1 7 2000

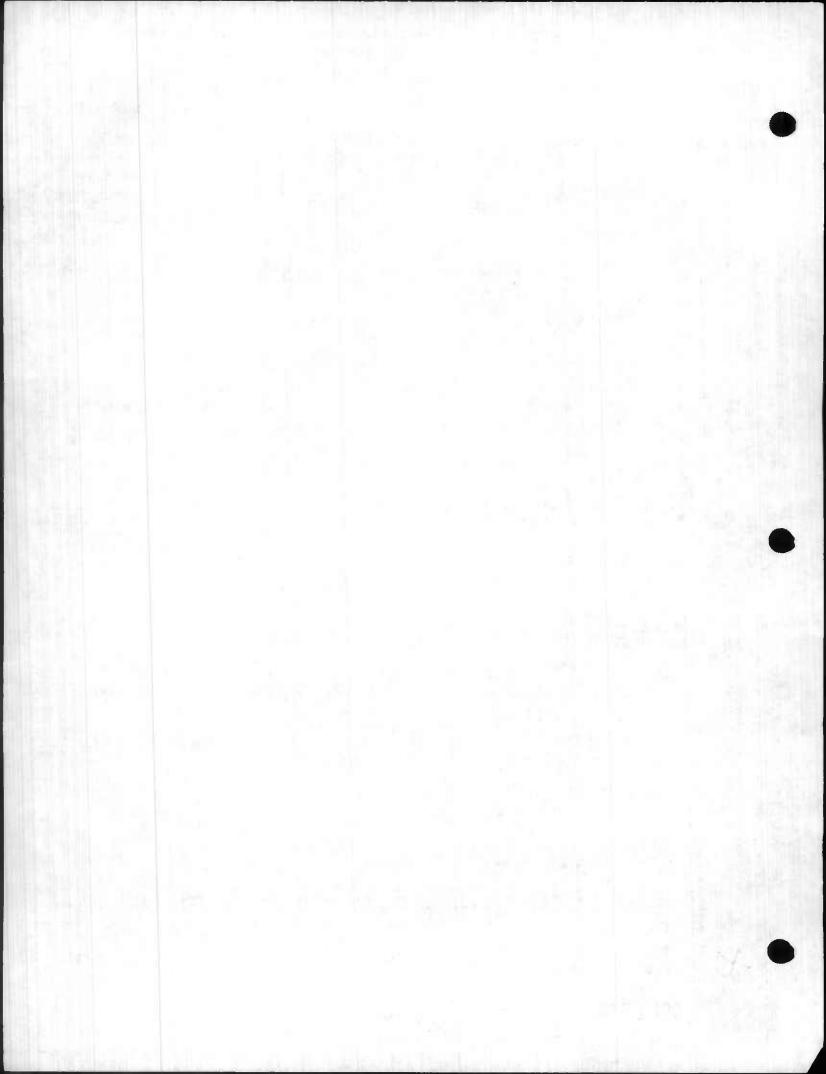
**DHMH 16 Rev 6/95** 



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State of Maryland / Department of Health and Mental Hygiene 0 0 327 | 9

			Certifica	te of Death		Reg. No.	06113					
Physician	1. Decedent's Name (First, Middle, Last)		Co		2. Dete of De Month		3. Time of Death					
/Medica		V ROACH,	24,		10		000 (0:52					
Examine	4a Facility Neme (If not Institution, give s	street end number) UNTY GENE	000 120501		or Location of Deets							
- L	5. Social Security Number 6. Sex			er 1 Year   If Under 24 H		How						
Funeral Director		7. Age (In yrs. k 7. Age (In yrs. k	Yrs. Month		in. (Month, Da	Birth Day, Year)  9. Birthplece (State or Foreign Country)  20, 1946 West Indies						
Mel/	10a. Stete 10b. County	10c. City	, Town or Location			10d. Inside City Limit						
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vith the Ma	10e. Sfreef and Number		10f. 2	ip Code		10g. Citizen of Wh	g. Citizen of Whet Country?					
th will	4405 Groveland Ave	enue	2	1215		USA						
21215-0020 d within 72 hours after death with the Maryland blene. In their "natural", or flerm 23s or 28s-f show, the Mardical Evantiver must be notified at	3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in U,\$ Armed Forces?  1 ☐ Yes 2 ☐ No ft Yes, Give Yeer or Detes:		edent of Hispenic Origin? ecity Cuben, Mexican, Pu 2 XNo Specify:	(Specify Yes or No erto Rican, efc.)	Black,	American Indien, White, etc. Black					
72 hours	15. Decedent's Educ (Specify only highest grede	cation	16e. Decedent's Us	uel Occupetion	working	16b. Kind of Busi	iness/Industry					
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Baltimore, Nomit: Pages 1 and Department of Health Integrant: if Itan 27 and Integration of Other transcents.	1 ☐ Buriel 2 ☐ Cremetion 3 ☐ R	emoval from State	metery, cremetory of	other piece)	Oct. 13.							
Baltimol Permit. Pages Department of Important: If it Inty injury or of	21. Signature of Funeral Service License			hington Crem	1+2000	Laurel,	Maryland					
Balti permit. Departm Importa eny inje	E1. Signaturo St Funeral Service Cicente	2 - ).	22. Neme	end Address of Fecility	Witzke F	uneral Ho	ome, Inc.					
	Medice 17 0x	apo	5555	Twin Knolls	Rd., Colum	mbia, Mar	yland 21045 Approximete					
	Part L Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line.											
Physician // // // // // // // // // // // // //	Immediate Ceuse (Final	D. 4.=.	0:4. /.				Onset and Deeth					
Examiner	disease or condition resulting in death)	DACTE	RIAL H	100CARDITI	5		2 weeks.					
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exect on and ital-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	Due to (or es e consequence of):										
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P.O. BOX the death cel d by the attendir etached for use	Pert II. Other significant conditions con	fributing to death but not resu	Iting in the underlying	cause given in Part I.	23b. Dld	tobacco usa cont	ribute to the cause of death?					
P.O. the the de by the detached	1. SARCOI	'Mac's	100		10	Yes 2 No	3 Probably 4 Unknown					
E X 7		100217			-							
Vital Records, P.O sician: The law requires that the certificate has been signed by the irector, page 2 should be detached.					24a. Wes	en eutopsy omed?	24b. Were eutopsy findings evailable prior to					
The law requir	3. GIBL	ea).		38.89-27-2			completion of cause of death?					
	4. CHROM	C RENAL IN	sufficted	scy.	10	Yes 212 No	1 ☐ Yes 2 ☐ No					
F Vital F	25. Was case referred to medical			26. Plece of (	Deeth (Check only	one)						
A Sila	1 ☐ Yes 2 No		ER/Outpatient 3		Home 5 Resi							
Ing P	27. Manner of Deeth  1 Neturel 5 Pending	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe	how injury occurre	d					
VISION Attending or death. ector: After by the fune	2 Accident investigation 3 Suicide 6 Could not be	CO. Discondition Assess	M	1 Yes 2 No	20f Location	Ctract and Alumba	s of Pivral Pauto Number					
그 오류들도	4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify,	me, farm, street, fact	ory, office	City or To	wn, Stete)	r or Rurel Route Number,					
To the Hospital of the Tro the Trongs and Tro the Transpal of		sician: To the best of my knowner: On the basis of examinetied menner stefed.	vledge, deeth occurre ion end/or investigeti	d et the time, dete and ple on, in my opinion, deeth o	ece, end due to the courred at the time,	ceuse(s) and man date and place, an	ner as stated. nd due to the cause(s)					
To the state of th	29b. Signeture end fittle of certifier		2	9c. License number		29d. Dafe signed	(Month, Day, Year)					
Pa	Shoped	em M	(1)	DOU 5023	35	10	17/00.					
~0	30. Name end address of person who co	moleted cause of death (Item	23e) (Type, Print)	8			1 '(					
	FERUZ A. PADDH	2 MO 11805 12	HIP Patux	ent Pkwy Si	rise lot,	COLUMBIA	1, MD 21044.					
State	31 Dela Liled (Manth Pay Year)	32. Registrar's Signat		,			,					



#### Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

S	Ramirez			State of Mary		epartment of Certificate of		Mental H	ygiene	0 32720		
	Physician /Medical	LUIS		EL RAMIRE	Z		4b. City, Town, or	2. Date of D Month Octob	er 13, 20			
	Examiner Funeral Director	919 SO 5. Social Securit		Street	yrs. last birth	Months Days	Baltimore N/A Year   If Under 24 Hrs.   8. Date of Birth   9. Birthplace (State or Foreign					
	aryland abow dat	Usual Residence 10a. State	e of Decedent 10b. County	100	City, Town	or Location IMORE		31	10d. Inside City Limits 1 🖾 Yes 2 □ No			
	ath with the Marys 23s or 28s-1 shor ust be notified at rai Director	MD.  10e. Street end 919 S		HAM STREET	DALI	10f. Zip Code	21224		10g. Citizen of V	n of What Country?		
020	ors after death at, or items 23 Examiner must by Funeral	11. Marital Statu			☐ Yes 2 No Yes, Give 17 Yes 2 N			Specify Yes or Note Rican, etc.)	Blac	a - American Indian, ck, White, etc.		
21215-0020 swittin 72 hours at plens. r than "natural", or the Medical Exam		15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondery (0-12) College (1-4or 5+) DISH					e during most of wa ed)	orking	16b. Kind of Bu	isiness/Industry		
/land	Mental Hygurked other arked other ark event,	17. Father's Nar	ne (First, Middle, Last)  X GABRIE		18. Mother's Name (First, Middle, Maiden Sumeme) VIRGILIA RAMIREZ							
re, Mar	Heath and I sho		s Name/Relationship (7 JRO GARCIA Disposition	AORTIZ	9 0b. Place of D	Disposition (Name of	OLDHAM	RE, MD. 2122 City or Town, State				
Itimor	arment of ortant: If it injury or it	1 Removal from State 4 Donation 5 Other (Specify)  21 Signature of Funeral Service Licensee  1 Removal from State 4 Donation 5 Other (Specify)  22. Name end Address of Facility CHARLES S. ZEILER & SON, INC.										
Ba	18118	23a, Part1, Ent	er the disease, or come	MICO Solications that caused the	62/	6224 EA	STERN A	VE., B.	ALTIMOR	C. E, MD. 21224	į	
	Physician /Medical Examiner	Immediete Cau- disease or conc resulting in deel	heart tailure. List only only only only only only only only	a. Acute Al	.cohol	Intoxicat:				Interval Between Onset and Death		
0,	be executed siclan and buriel-transit	Sequentially list if any, leeding to cause. Enter U Cause (Disease										
x 68760,	ficate physics the edic	that initiated ever resulting in deal	ents									
, P.O. Box	that the death and by the etter detached for y Physician	Pert II. Other sig	gnificant conditions co	intributing to death but no	t resulting in t	given in Part I.		d tobacco use co ☑ Yes 2☑ No	ntribute to the cause of death			
Records	been should							24a. Wa	as an autopsy dormed?	24b. Were eutopsy findings aveilable prior to completion of cause of death?		
Vital Re	certificate has rector, page 2	25. Was case re	eferred to medical				26. Place of De	eath (Check only	Yes 2 No	1 No 2□ No		
Division of V	hya his	15 Yes 2 27. Manner of D 1 Natural 2 Accider	5 Pending investigation	2 ER/Outp 28b. Tir Inj Four 9:0	ne of 28c. Inj		28d. Describ		ted alcohol.			
Divis	* # # E	3 Suicide 4 Hornicid	de determined	building, etc. (S)  FOU	nd: F	n, street, factory, office  OW HOUSE  deeth occurred at the	time, dete end plac	Street	, Baltime	per or Rurel Route Number, und: 919 Oldha ore, Maryland. anner es stated.	n	
	To the Hospital of within 24 hours at To the Funeral Discompletely filled in Medical Cel	(Check only one)	2 Medical Exam	iner: On the basis of exer and manner stated.	mination and/	or investigation, in my	opinion, death occ	curred at the time	e, dete end pleca,	and due to the cause(s)		
	2 2 2 2	Mo	end title of certified	ethill	flance on the	0.	.C.M.E.			14, 2000		
	200		ddress of person who d	completed cause of death	(itemi 23a) (T	ype, Print)	Sharet D	-144	a Mars-1			

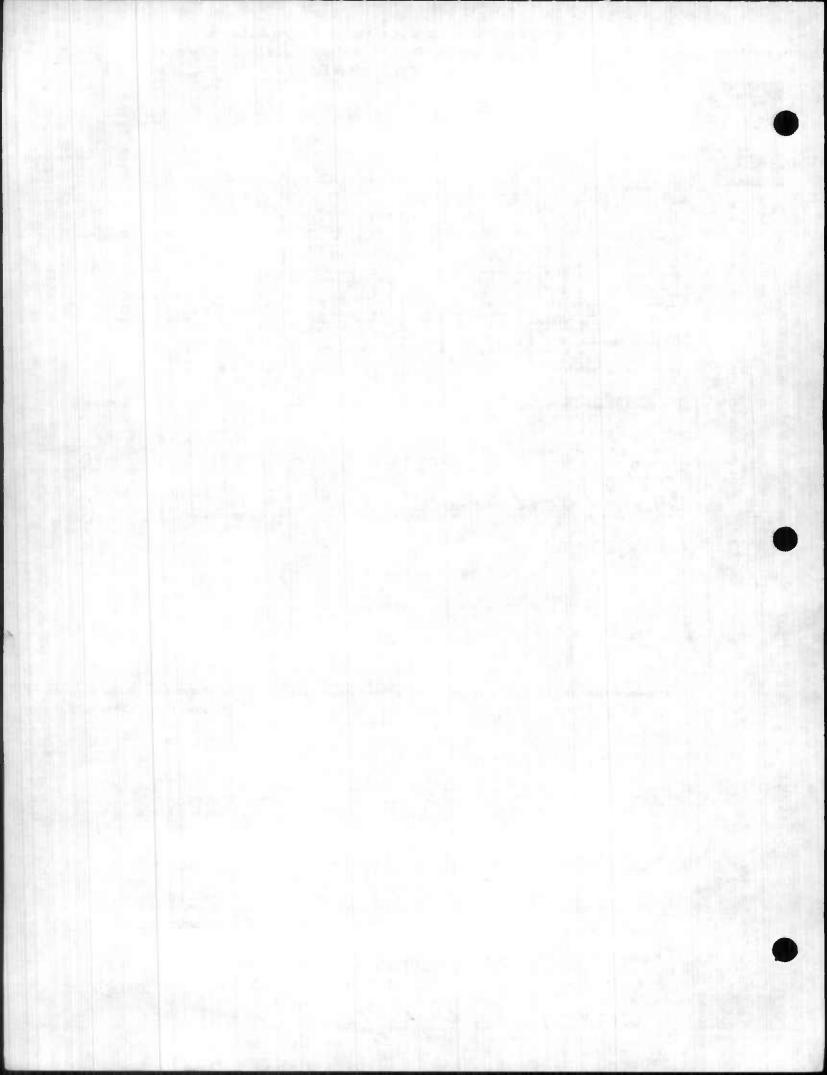
State Registrar DHMH 16 Rev 6/95

OCT 1 7 2000

31. Date filed (Month, Dey, Year)

32. Registrar's Signeture

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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Department of	Health an	d Mental	Hygiene
0-46-4-	1011		

n al						. No.							
_	1. Decedent's Neme (First, Middle, I	Last) SIM	PKINS		2. Dete of Deeth Month	Day	Year 3. Time o						
	SANDRA		12/105	4h City Town or los	OCT /		000						
r	4e Fecility Name (If not Institution, g	HOSOITAL		4b. City, Town, or Loc	no-e	4c. County o	of Death						
	-,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	. Sex 7. Age (In yrs.		ear If Under 24 Hrs.	8. Date of Birth		9. Birthplace (Steta						
	217-64-6295	1□ M 2□ F 46	Yrs. Months Da		(Month, Day, Y	1954	g. Birthplace (Steta Country) Maryland						
-	Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or Location				10d Inelde C						
-	Md. Howard		lkridge		10d. fnslde City Limi t ☐ Yes 2/2/1								
Directo	10e. Street and Number		10f. Zip Cod		10g. Citizan of What Country?								
		۸.,,,,,,,		1075									
	6636 Highland /	12. Wes Decedent Ever in U.		TU75 of Hispanic Origin? (Spe Juben, Mexicen, Puerto F	cify Yes or No-		- American Indian,						
	1 Never Married 2 Married	If Yes, Give	If Yes, specify C		Rican, etc.)	Specify:	k, White, etc. white						
-	3 🕅 Widowed 4 ☐ Divorced  15. Decedent's	Year or Detes:	16a. Decedent's Usual Oc	cupation	16	b. Kind of Bus	siness/Industry						
od within 72 ho ygiene. wer than "nathur At, the Medical. Completed	(Specify only highest g	grede completed)	(Give kind of work do life. DO NOT use re	ne during most of working	19								
5	Elementery/Secondery (0-12)	College (1-4or 5+)	Assemble	r	Ciena Co		na Corp.						
	17. Father's Neme (First, Middle, La.	st)	18. Mother's Name (First, Middle, Maiden S										
2	Frank William	Jackson	Doris El	Elizabeth Wingate									
aath and n 27 is m ser traum	19e. Informent's Neme/Reletionship	(Type, Print)					Stete, Zip Code)						
	Wayne Cooper -		6636 Highla				21075						
	20a. Method of Disposition		lece of Disposition (Name of emetary, cremetory or other	plece) 1	Date 20		City or Town, State						
	1 Removed from State  1 Removed from State  4 Donetion 5 Dother (Specify)  1 Removed from State  Meadowridge Mem. Park  10/19/00  Elkridge, Md.												
	21. Signature of Funeral Service Lic	ensee	22. Name end Ad		nal Home	@ Moad	ownidae MP						
Gary L. Kaufman Funeral Home @ Meadows 7250 Washington Blvd., Elkridge, Md.  23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory errest.													
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	Immediata Causa (Finel disease or condition resulting in death)  e. /twe Mycannel Infancion 5 /2 /aur  Due to (or as a consequence of):												
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Dy Physician/medical	that imitated events resulting in death) Lest	c Due to (o	r es e consequence of):	given In Pert I.		2□ No	3 Probably 4  24b. Were autopsy available prior completion of						
	that imitated events resulting in death) Lest	c Due to (o	r es e consequence of):	given In Pert I.	1 Yes	2□ No autopsy	24b. Were autopsy available prior completion of death?  45  24b. Were autopsy available prior completion of death?						
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 32722 Amended Item#8 perABG788 10 17/2000 EW Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3. Tima of Death Month Day 2:04Pm OMMER 2000 6 ty Name (It not institution, give street end number 4b. City, Town, or Location of 4c. County of Death BALTIMORE AND ALLStown If Undar 24 Hrs. a Da 2-21-19 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Months Days Hours -01-1 □ M 595 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits MD Baltimore Randallstown 1 ☐ Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9109 Liberty Road 21133 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: white 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry unk 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 typist 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surnema) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Genesis Randallstown 9109 Liberty Rd Randallstown, MD 20b. Place of Disposition (Neme of cemetery, crametory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removet from State 4 ☐ Donetton 5 ☑ Other (Specify) In State Ronald Service Licensee Wade, State Anatomy Board Director 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part1. Enter the disease or complications thet causad the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, mock, or heart feilura. List only one cause on each line. Approximate tritervel Between Onset and Death Immediata Causa (Final diseese or condition resulting in death) INFARCTION MYOCARDI Due to (or es e consequence of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of) Dua to (or es a consequence of): 23b. Did tobacco use contributs to the cause of death? 3 Probably Wunknown 1 Yes 2 No 24b. Were autopsy findings 24a. Was en eutopsy performed? ANEURY

Physician /Medical - weithinks

bunal-transit

ed by the a

After this

death.

after death Director:

24 hours Hospital

within 24 ho To the Fune completely f To the

yd ni bellil

29e. Certifier

838

29b. Signature and title of certifie

31. Data filed (Month, Dey, Year)

GREENZ

**Physician** 

/Medical

Examiner

**Funeral** 

Director

rai', or items 23a or 28a-f show Examiner must be notified at

Pages 1 end 2 should be filed within 72 hours after ent of Heelth end Mentel Hygiene.

nt: if Item 27 is marked other than "natural", or ite

7 is marked of

Depertment of Important: If It is any Injury or or once.

Maryland 21215-0020

Baltimore,

Box 68760. certificate be

P.O.

Records.

Division of Vital or Attending Physician:

The law has

permit.

Director

Funeral

PV

Completed

the Manfend

Completed by Physician/Medical Examine Be To Certification:

that initieted events resulting in death) Last Pert ff. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. available prior to complation of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case refarred to medicel examiner? 26. Place of Death (Check only one) examiner? Hospitaf: Other: 4 Aursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred 1 Neturef 2 Accident 5 ☐ Pending 1 Yas 2 No investigetion 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

SUITE

052360

300

29d. Date signed (Month, Day, Year)

Salt ans

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PILESVIU

State Registrar

DHMH 16 Rev 6/95

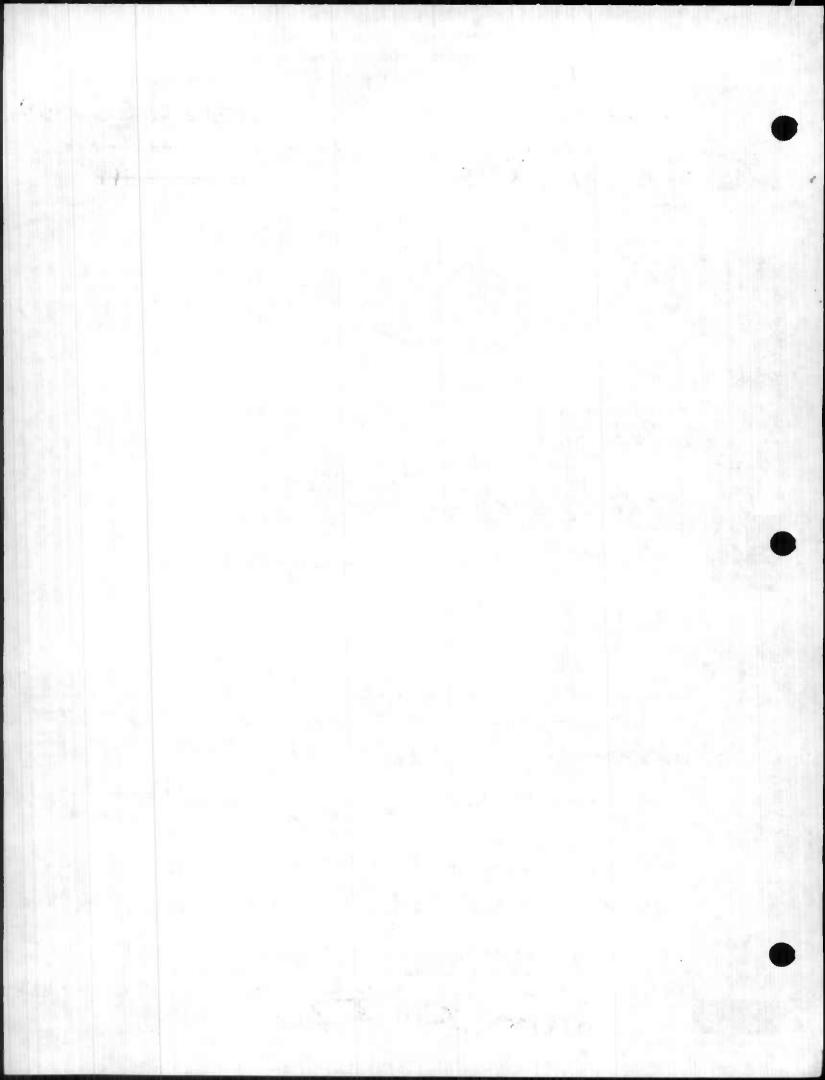
NO

w 30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print) 1 CU 312 SAN DEU

TRZE

32. Registrer's Signature

2000



# INDFLLA KNONN

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death : 28 am MINDELLA SCOTT OCTOBER 16,2000 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSPITAL OF BALTIMURE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Deta of Birth (Month, Dey, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) Months Days 1□M 20 F 98 Yrs. 213-20-7939 Usual Residence of Decedant 902 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 No BALTIMORE NA 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3939 PENHURST AVENUE 21215 USA 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian. Black White Ctan 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married 1 ☐ Yas 2 No Specify: Specify: AMERICAN 3 Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th NURSES AIDE HEALTH CARE NA 17. Fether's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Sumeme) CHARLES SCOTT ANNIE LEE 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 34 MARKET PLACE SUITE 300 BALTIMORE MD CARLA RANSOM (GUARDIAN) 21202 20b. Piaca of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 N Burial 2 □ Cramation 3 □ Removat from Stata 4 Donation 5 Othar (Specify) MOUNT ZION CEMETERY 10/18/00 LANSDOWNE, MD 21. Signature of Funara Sarvica L 22. Name and Addrass of Facility WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 23a. Part 1. Enter the disaesa, or complications that caused tha death. Do not antar tha mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause or each line. Approximate Interval Betw Immediata Cause (Finel disaase or condition resulting in death) PNEUMONI Dua to (or as a consequence of) Dua to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown VASCULAR ACCIDENT 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

**Physician** /Medical Examiner

Box 68760.

P.O.

of Vital Records.

Division

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for the hywithin 24 hour.
To the Funeral Directory that in

Examine

Physician/Medical

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Completed

Certification: To Be

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Pages ment of

**Physician** 

/Medical

Examiner

10a Stata

MD

Director

Funeral

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**Funeral** 

Director

Herne 23s or

I Hypiene, other than "natural", or Hem vent, the Medical Examiner

Mental

Sequentially list conditions, if any, leading to immadieta causa. Enter Underlying Cause (Disease or injury that Initiated avants resulting in death) Last

PARDIAC ARRYTHMUAS 1 ☐ Yas

2 No 1 Yas 2 No

25. Was case refarred to medical 1 Yas 2 No

26. Place of Death (Check only one) Hospital: Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred

27. Manner of Death 1 Naturel 5 Pending invastigation 2 Accident 3 ☐ Suicide

6 Could not be detarmined 28a. Placa of Injury - At homa, farm, streat, factory, offica building, etc. (Specify)

1 Yas 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only

4 Homicide

1EC Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examinetion and/or invastigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signatura and title of cartifier lleer,

29c. Licensa number RES OOU

OCTOBER 16, 2000

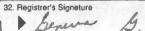
29d. Date signed (Month, Day, Year)

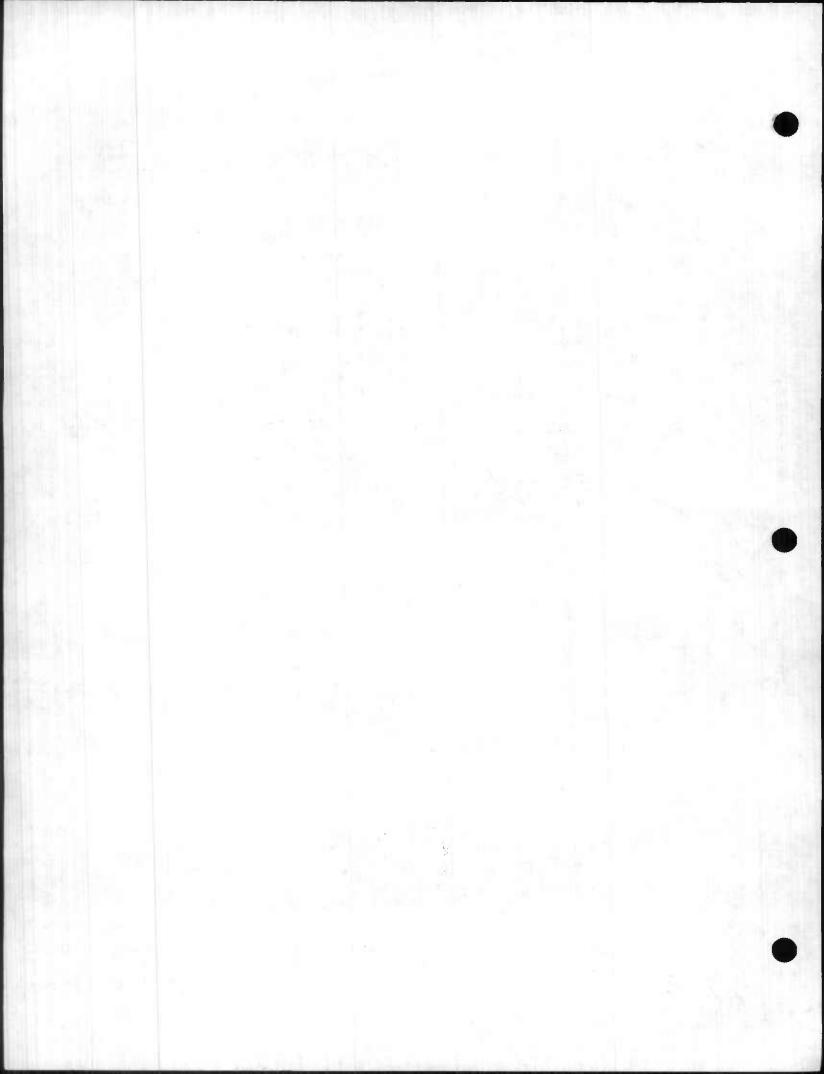
30. Name and address of person who complated causa of daeth (Item 23a) (Type, Print)

2401 WEST BELVEDERE AVENUE, BALTIMURE, MD 21215

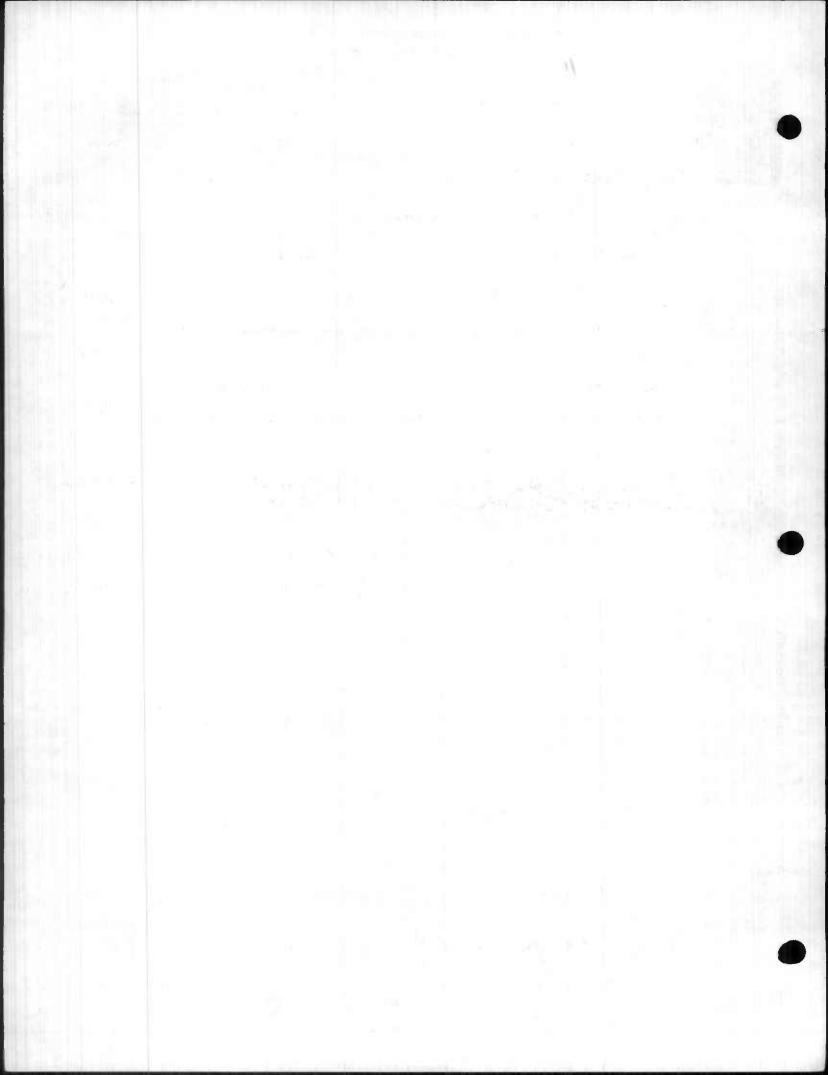
State Registrar

SHAH, D.O. 31. Deta filed (Month, Day, Year)





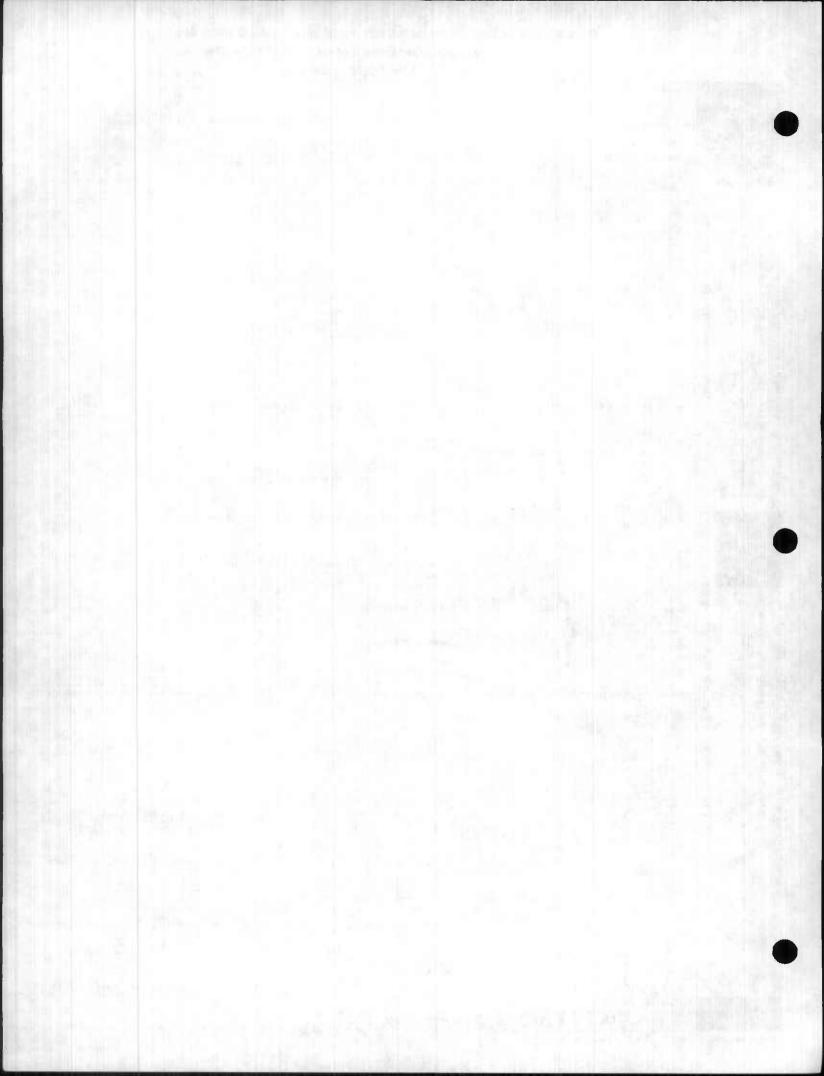
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23a or 2	200	Funeral Director	10e. Street and Numbar 98 Smithwood Stre	et		10f. Zip Coda	21228		10g. Citizan of V US		itry?	
ral", or items 23s or 28s-f show		by	11. Maritai Status  1 ☐ Navar Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedant Even Armed Forces? 1 ☐ Yes 2 No If Yes, Giva Yaar or Datas:	ar in U,S. 1	3. Was Decedant of If Yas, specify Cu 1 ☐ Yas 2 ☒ No		pacify Yas or No to Rican, atc.)	Specify	ck, Whita,	can Indian, etc.	
r than "natural".		Completed	15. Decadant's E (Specify only highast gr	ducation ada complatad)	16a. Da	16a. Dacedant's Usual Occupation (Giva kind of work dona during most of w lifa. DO NOT usa ratired)		f working		. Kind of Businass/Industry		
ther than	1	ш	Elementery/Secondery (0-12)	College (1-4or 5+)	Inte	secretary			rea	l est	ate	
the			17. Father's Name (First, Middle, Last			Secretar.		ma (First, Middle	, Maidan Sumen		acc	
Ore, Marylar jes 1 end 2 should be t of Heelth end Menta if from 27 is marked or other treumetic ev	To Be	George Lynn					Fischer					
		19a. Informant's Name/Ralationship ( James Linsley/sor			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zlp 9406 Joey Drive Ellicott City, MD 2104							
		20a. Method of Disposition  1 Burial 2 Cramation 3 4 Donation 5 Other (Space)		20b. Place of Dis cematary, o	sposition (Nama of crematory or other pi	iace)	Deta	20c. Location -	City or To	wn, Stata		
Important:	once		21. Signature of Funeral Service Lice Ronald S		5-2-1000	State Anatomy Board 655 W. Balt: Baltimore, MD 21201					Street	
olei	20		23 Entar the disease, or com- nick, or haart failura. List only	plications that causad the ona cause on each line.				c or respiratory e	rrest,		Approximate Intarval Batwaen Onset end Daath	
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the fune		atio	1 Naturel 5 Panding 2 Accidant invastigatio	n	dar/ Injur		Yas 2□No					
ed in by the		Certification:	3 Suicida 6 Could not be datarmined	28a. Placa of Injury building, atc. (		streat, factory, office	9	28f. Location ( City or To	Straat and Numb wn, State)	er or Rure	al Routa Number,	
To the Funerel Direct completely filled in by		edical		nysician: To the best of miner: On the basis of ax and manner states	amination and/or							
To the									29d. Data signe	d (Month,	Day, Year)	
		-	Ram S. Ka	ypruen	M.D	D2	6307		10-2-	-		
			30. Nama and address of person who	domplated causa of deat	4	pe, Print)	201102	0 0 0	C 1	1=	110 110	
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16 Day	6/95		001 = 1	/								



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32725

			Certificate of Death Reg. No.											
		1. Decedent's Name (First, Middle, L	ast)						2. Date of Deeth		Vans	3. Time of	Death	
	Physician	CLARA	VIRGINIA	1	S	TEP:	HAN		Month OCTOBER	Day 13, 2	Year 000	7:27	AM	
	/Medical Examiner	4e Facility Name (If not institution, gi						wn, or Lo	cation of Death	4c. County	of Deeth			
	Examiner	ANNE ARUNDEL MED	TCAL CENTER				ANNZ	POLI	S	ANNE	APIINI	OFT.		
	Funeral			n yrs. last birthday,	ff Under 1	-	If Under	24 Hrs.	8. Date of Birth (Month, Day,		9. Birthp	lece (State of	r Foreign	
	Director	218-36-5229	1□M 2/QF	91 Yrs.	Months	Days	Hours	Min.	(Month, Day, Year) Country) FEB. 27, 1909 MARYLAND					
	70	Usual Residence of Decedent								, 1000				
	how	10a. Stete 10b. County	01 A A A A A A A A A A A A A A A A A A A	c. City, Town or L	ocation						1	0d. fnslde Cit		
	Me Me	MARYLAND ANNE A	RUNDEL	PAS	ADENA							1 Tes	ZIA No	
	vith the Me. t or 28s-f s be notified Director	10e. Street and Number			10f. Zip C	ode			10					
	death with the Meryland ms 23s or 28s-f show rmust be notified at	363 NORTH SHORE	ROAD		21	1122	2			U.S.A.				
		11. Maritei Stetus	12. Was Decedent Eve Armed Forces?	r in U,S. 13.	Was Deceder	nt of Hi	spanic Or	igin? (Spe	ecify Yes or No- Rican, etc.)	- Americ	en Indian, etc.	- 30		
0	or in		1 Yes 2 No		1□ Yes 2₺					Specity	*.7	HITE		
00	72 hours after natural, or its acal Example eted by Fu		Year or Dates:				-,,-		Specily.					
21215-0020	ed within 72 hours aft yglene. er than "natural", or ft, the Medical Exam Completed by F	15. Decedent's E (Specify only highest g	Education rade completed)	(Give	dent's Usual ( kind of work	done d	luning mos	t of worki	rking 16b. Kind of Busines			dustry		
121		Etementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use									
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no Du	He dott	17. Father's Name (First, Middle, Las ELLSWORTH		TOVELL					ame (First, Middle, Maiden Surname)  FORD					
Z	should be filed within and Mentel Hygiens. I marked other than umatic event, the Manual To Be Comp	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code												
Maryland	0 0 0	JACK E. STEPHAN (SON) 363 NORTH SHORE ROAD, PASA												
re,	Department of Health moortant: If Item 27 any Injury or other to	20e. Method of Disposition 20b. Place of Disposition (Name of Dete 2										wn, Stete	1.15	
Baltimore	Pages nent of int: If he iry or o	1X Burlal 2 ☐ Cremation 3 0							10/16/20		IRNIE	MD		
alti	Department Department Important: I eny Injury o	4 Donation 5 Other (Specify)  GLEN HAVEN MEMORIAL PARK  GLEN BURNIE, MD.  21. Signifure Funds Service Leases  22. Name and Address of Facility  SINGLETON FUNERAL HOME, P.A.,												
Ö	Depa Impo eny li	1 45 WH	agan	1	SECON	D A	VENUE		W., GLEN					
		23a. Part1. Enter the disease, or con shock, or heart failure. List only							-			Approximete Interval Bety	9	
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	/Medical	Immediate Cause (Finel disease or condition	dale	. O. 1	, Car	1 -	10	Ary Or	n dis	2010		54	M.	
	Examiner	resulting In death)	e. 7/1 7000	e to (or as a conse	equence of):	JUL	2072	you	N(	-10-2	1	1		
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	ate be executed hysician and the burial-transit	Sequentially list conditions,	Du-	e to (or as a conse	quence of):	77								
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68760	ficate be so physician as the buria	Cause (Disease or injury that initiated events resulting in death) Last	C. Due	to (or as e conse	quence of):	1.7					1	1-31-1		
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Box	d by the attendi		I d											
_ 0	that the death ce ed by the attendi deteched for use	Part II. Other significant conditions	contributing to death but n	ot resulting in the	underlying ceu	se give	en in Part	I.	23b. Dfd tol	bacco use co	ntribute to	the cause o	of death?	
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	20 00 00										r			
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æ	The lay page 2								1 ☐ Ye	s 2 No	10	∃Yes 2□	No	
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1	2 00	examiner?	Hospital: 1 Inpatient	2 ER/Outpatie	ent 3 DOA	Oth	er: 4□N	ursing Ho	me 5 Reside	nce 6 Oth	er (Specif	(y)		
Jo L	ding Ph h. After th funeral		28a. Date of Injury (Month, Day Y	aar) 28b. Time (	of 280	. Injun	at c?	12-1	28d. Describe ho	w injury occur	red			
0	Attending in death, actor: Afte by the fune	1 Natural 5 Pending investigation	on		М	10	Yes 2	No						
Division	is or Attending Ph is after death.  Ill Director: After th and in by the funeral Certification: "	3 Suicide 6 Could not determine	be d 28e. Plece of Injury building, etc. (	- At home, farm, s	treet, factory,	office			28f. Location (Str City or Town		er or Aure	A Route Num	ber,	
	Blor A										313			
	24 hour Effurent etely III		hysician: To the best of m	ny knowledge, dea aminetion and/or in	th occurred at	the tim	ne, date a	nd place, ath occurr	end due to the ca	use(s) and ma	anner as s	tated. the cause/s	.)	
	The state of the s		and manner stated											
-	9143	29b. Signature and titlelot continue	^		290.	License	number	7	25	d. Date signe	/Z-	- IA		
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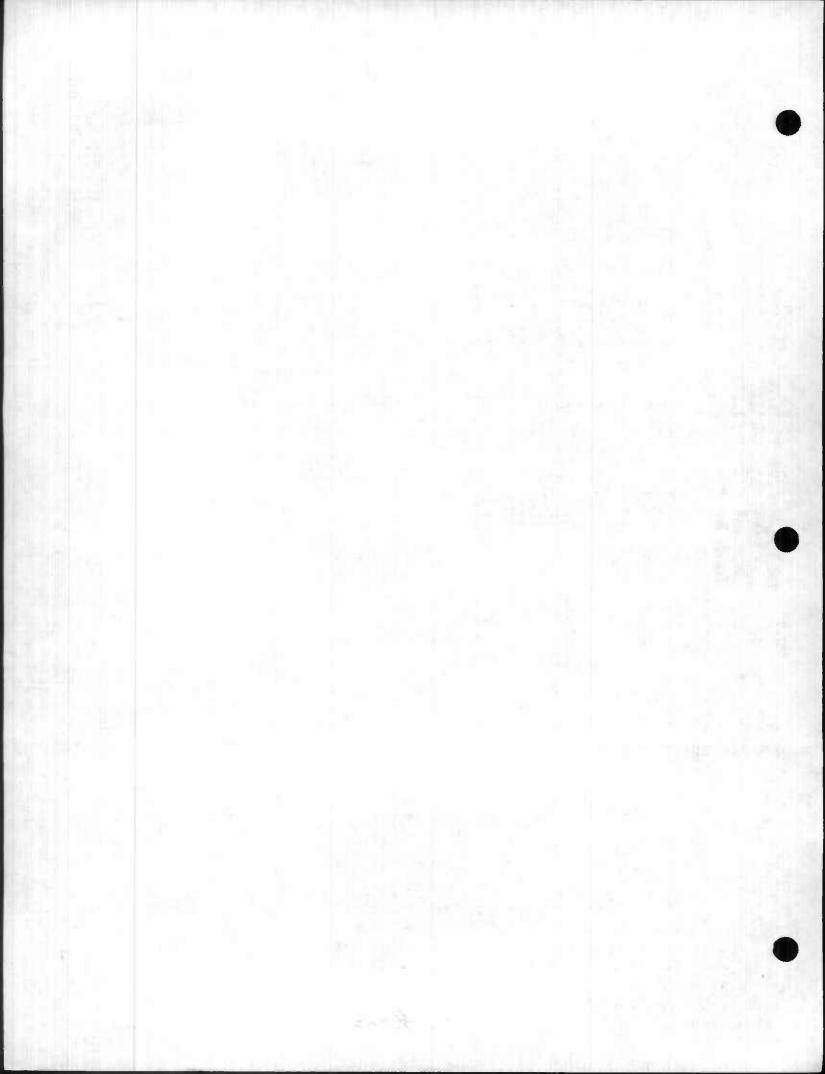
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Certificate of Death Reg. No.				
State of Maryland / Department of Health and Mental Hygiene	0.0	327	126	
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		Certificate of Death Reg. No.											
		1. Decedent's Name (First, Middle, Last	)	100				2. Date of De Month	eth Dey	Yeer	3. Time of Death		
	Physician /Medical	Richard B. S	hock					Oct.	12.200		7:20 AM		
	Examiner	4a Facility Name (If not institution, give	street and number)				4b. City, Town, or			y of Death			
		3017 Reckord	Road				Fallsto	n	Harford				
	uneral irector		x 7. Age (In )	yrs. last birthda Yrs.	Months	Days	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, Da Sept 18	th ly, Year)				
		Usual Residence of Decedent						10000	11000	1101	. y zama		
ylan	How	10e, State 10b. County	10c.	City, Town or	Location						10d. Inside City Limits		
Ma	28a-f shownoutling at	MD Harford		Falls	ton				1 □ Yes 2(□ No				
death with the Maryland	frems 23s or 28s-fe free must be notified Funeral Director	10e. Street and Number			10f. Zi	p Code			10g. Citizen of What Country?				
W fi	23a or	3017 Reckord Ro											
Urs after		11. Marital Status  1 Never Married	12. Was Decedent Ever in Armed Forces?  1 12 Yes 2 12 No if Yes, Give Year or Dates: Korn				dispanic Origin? (S an, Mexicen, Puerl Specify:	pecify Yes or No to Rican, etc.)	Bio	ca - Ameri ack, White fy: Whi			
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	d otherward,	17. Father's Neme (First, Middle, Last)					18. Mother's Ner	me (First, Middle					
Baltimore, Maryland 212 semit. Pages 1 and 2 should be filed withi spearment of Heath and Mental hygiena. mportant: if item 27 is marked other than ny polury or other traumetic event, the M and. To Be Comp	Charles Shock					Helena	Brook	S					
Aary 2 shou and M 1s mer		19a. informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or in the street and Num								, State, Z	ip Code)		
	27 l	Beth D. Shock (	d Rd Fa	allston	, MD 2	1047	7						
Baltimore,	£ 4	20a. Method of Disposition	20c. Location	Location - City or Town, State									
Pages Pent of	7 2	1 N Buriel 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	BelAir Me	,			1/16/2000	BelAir.	MD			
Baltim permit. Pag Department	mportant: any injury ance.	21. Signature of Funeral Service Licens		-			ss of Facility						
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3	ial-transit Examiner	b											
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Records, he law requires th	d by							24a. Was	an autopsy		Were autopsy findings		
Ö E	page 2 should Completed						1.5	perfe	ormed?	C	evailable prior to completion of cause of death?		
e law	has mp										_		
<u>a</u> = <u>a</u>	r. page								Yes 22 No	1	I□Yes 2 No		
	director, page 2	25. Was case referred to medical examiner?	Hospital:			Ott	hor	eth (Check only					
Division of Vital for Attending Physician: Taffer death.	this ald	1 Yes 255 No	1 L Inpatient	2 ER/Outpati		OA	4 Li Nursing P		how injury occi		ify)		
C 2	Ion ion	Natural 5 Pending	28a. Date of Injury (Month, Dey Yea	r) Injury		28c. inju Wo	rk? Yes 2□No	200. Describe	now injury occi	MIOU			
VISION Attending	al Director: After to led in by the funeric Certification:	Accident investigation  3 Sulcide 6 Could not be	One Please of lainer	At the same of the same of			1165 2 110	28f Location	(Street and Nun	her or Ru	iral Route Number,		
or A	olrec in by	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	ecify)	street, facto	ry, onice		City or To	wn, Stete)	ibei oi riu	var riodie radiiber,		
To the Hospital	To the Funeral Director: After the completely filled in by the funeral Medical Certification:		Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.										
1 24 F	Puner plately fill edical	(Check only and dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.							, and due	to the cause(s)			
64	To the	29b. Signature and title of certifier	M >		25	9c. Licen:	se number		29d. Date sign	ed (Month	n, Day, Year)		
100	V	1 Wy	IN D	ND DISUS			8487	487 10/200					
- 1	170	30. Name and address of person who co	ompleted cause of death	(Item 23a) (Typ	e, Print)	2.0	10/		10/1	1			
0	LU	MYO THANT		050170		DR	IVE, 1	3HL70	, MO	21	237		
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#### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#10ePER F.H. G788 10-16-2000 JAB 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Yeer Month 1125 AM Physician EMMA SAVOY OCTOBER 13 2000 /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not Institution, give street and number) 4c. County of Death Examiner BALTIMORE HOS PITAL SECOURS If Under 1 Year | If Under 24 Hra. 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign 5. Social Security Number 6. Sex **Funeral** Deys Months Hours 10M 20F 218-01-2724 Usuel Residence of Decedent ME Director the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count 28a-f show treumstic event, the Medical Examiner must be notified at mo 1 1 Pres 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5215 SAYBROOK RD. Nerna 23a or filed within 72 hours after death 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify Maryland 21215-0020 8 py 3 Nidowed 4 □ Divorced "natural", Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiena. Elementary/Secondery (0-12) College (1-4or 5+) mT-Vernon 110 Whowen 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) la marked of 8 unknown Jase 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 2/26 C 19a. Informent's Neme/Reletionship (Type, Print) Pages 1 and 2 s ment of Health an permit. Pages 1 and 2: Department of Health at Important: If Item 27 is any Injury or other tree page. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) of BATTO.Ma ALL AKA Baltimore, Date 20c. Location - City or Town, Stete 2 Cremetion 3 Removel from Stete howns ville VA. Cem Donetion 5 Other (Specify) 22. Name and Address of Fecility unenal Jullo dedline ST. BAIN. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical FIBRILATION Atrial Examiner Due to (or as a consequence of) Physician/Medical Examiner Hypertension that the death certificate be executed Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Seizure disorder Box 68760, been signed by the attending physician should be datached for use as the buria Due to (or es e consequenca of): orebral rascular accident Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Chronic memig of Vital Records, Be Completed by 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24e. Wes en eutopsy pertormed? this certificate has ral director, page 2 Gonty Gotton tos 1 Yes 2 XNo 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Medical Certification: To To the Hospital or Attending P.

within 24 hours after death.

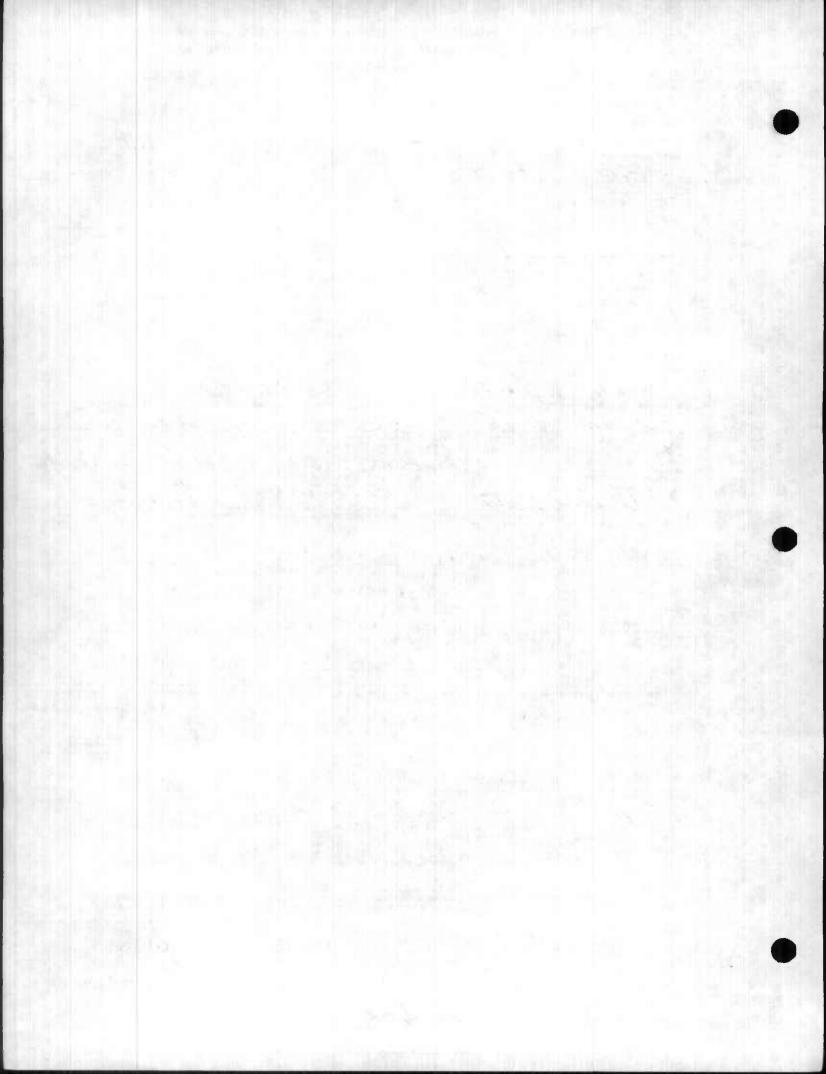
To the Funeral Director: After the Commission of the comm 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Division 1 Netural 5 Pending 1 Yes 2 No 2 Accident investigetion 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 T Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted. 29a. Cartifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 030115 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 2600 Liberty Baltimore mo 21215 hiokpehaim HUTS AVE 31. Dete filed (Month, Day, Year) 32. Registrer's Signature

DHMH 16 Ray 6/95

Registrar

OCT 1 7 2000



### Please Type or Print in Black indelible ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: 16A PER F.H. G788 10-17-00 WR. Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month MAY 5 00 PM ATHARINE SCALONE 2000 10 13 /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** PINEWOOD 2823 AUE. BALTIMORE BALTIMORECH If Under 24 Hrs. Hours Min. If Under 1 Year 5. Sociel Security Number Birthplece (State or Foreign Country) 6. Sex 7. Age (in yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** 1□M 2 F Months Deys 215-56-0783 Yrs. Director MD 11/26/22 Usuel Residence of Decedent 72 hours after death with the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Peges 1 end 2 should be filed within 72 hours after death with the Maryle nent of Health and Menth Hygiene. In marked other than "naturel", or frems 23a or 28a-f show that if them 27 is marked other than "naturel", or frems 23a or 28a-f show yor or other traumatic svent, in a facilitie Examiner must be notified as 28a-f show Yes 2 No Director BALTIMORE 10e. Street end Number 10g. Citizen of What Country? 2823 USA INE WOOD ANE 21214 Funeral 12. Was Decedent Ever In U.S. Armed Forces? 1 Yes W No If Yes, Give Year or Detes: 14. Rece - American Indien, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Merried Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) SECRETARY KDNEY FOUNDATION N/A 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be MAY CROSS 10 MARTIN MAYFORT CLARA 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3ALTO, MD. 21214 2823 PINEWOOD AVE JOSEPH P. SCALONE/HUSBAND 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1. Burial 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Pege Department of Important: If any Injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) 10/17/00 BALTO, ND. GARDENS OF FAITH 21. Signeture of Funerel Service Licensee

22. Name and Address of Facility

23. Name and Address of Facility

24. Name and Address of Facility

25. Name and Address of Facility

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21. Signeture of Funerel Service

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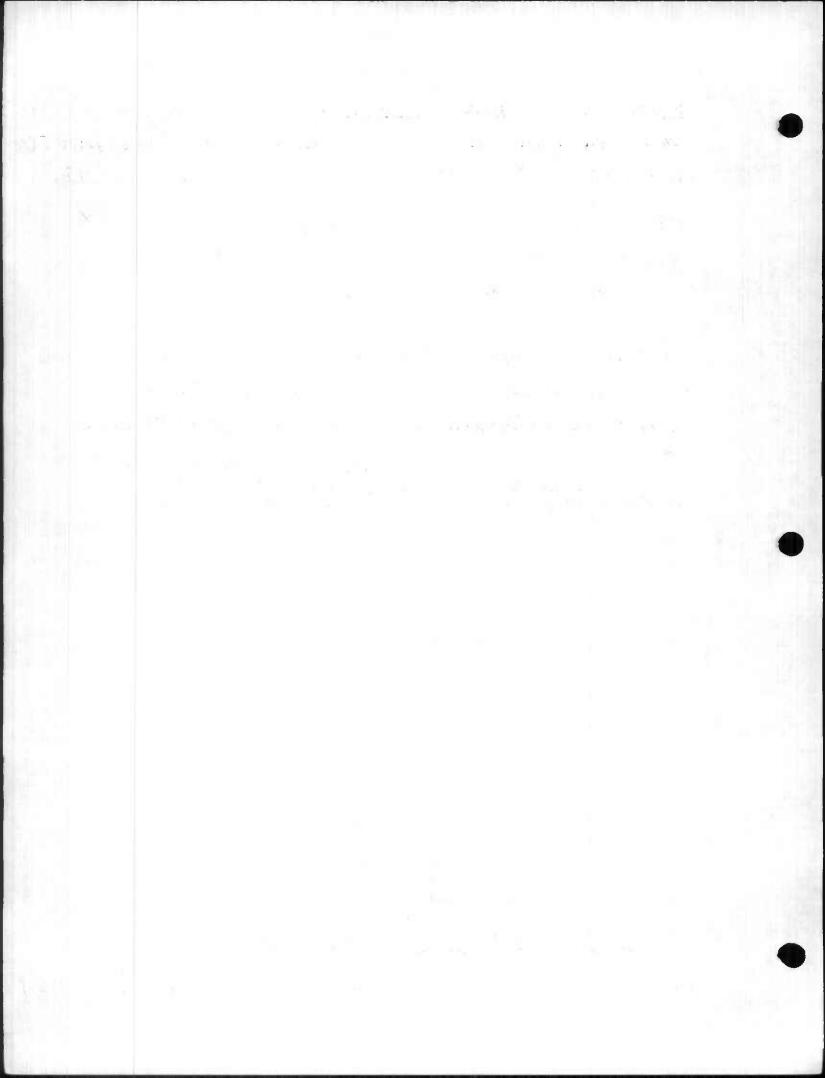
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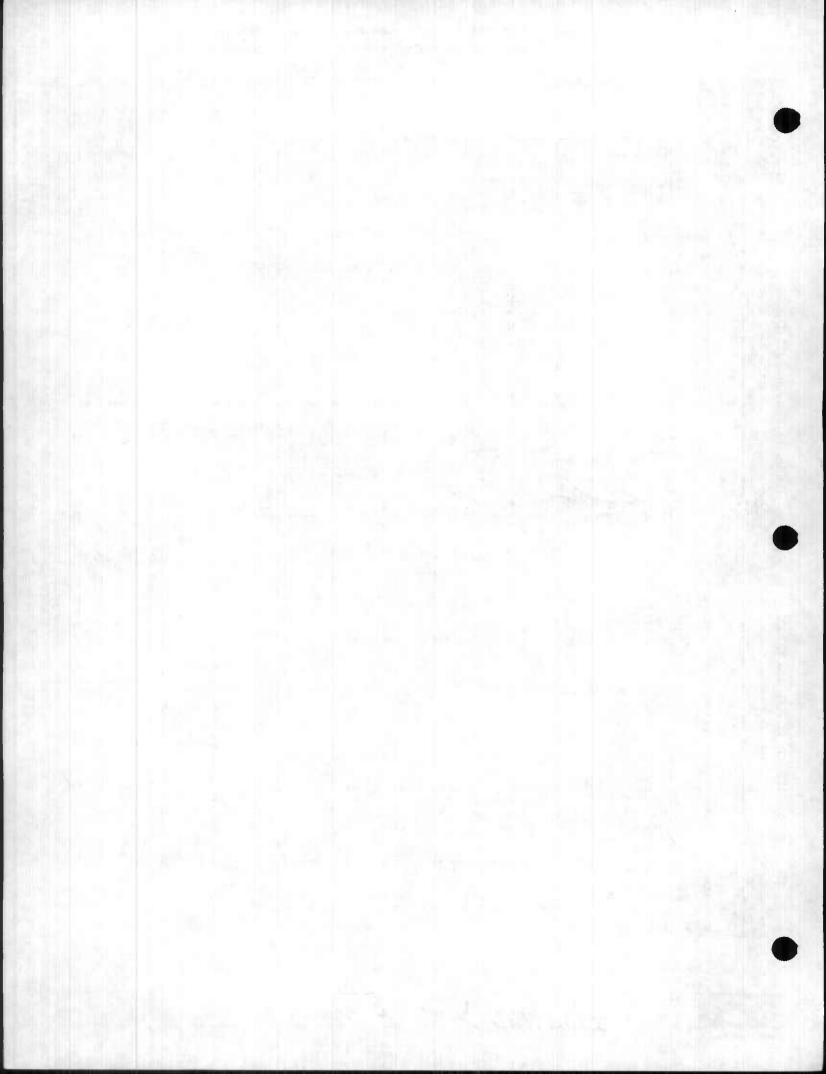
29. Name and Address of Facilit 22. Name and Address of Facility RAL Home, P. A. RLTENBURG FUNERAL HOME, P. A. 6009 HARFORD ROAD BALTIMORE, MY 21214 Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical LUNG CANCER ONE YEAR Examiner Due to (or es a consequença of) Examiner or Attending Physician: The lew requires that the death certificate be executed Sequentietly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of) Box 68760. Physician/Medical Due to (or es e consequença of) Division of Vital Records, P.O. been signed by the a should be deteched Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 | No 3 | Probably 4 | Onknown þ Completed 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en autopsy performed? 1 Yes 2 12 No 1 ☐ Yes 2 ☐ No certificate director 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) 1□Yes 2☑No Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28a. Dete of tnjury (Month, Day Year) Medical Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Pretural s effer deeth.
I Director: Aft
of In by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled the Hospital 1 ☐ Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) end menner es steted.

2 ☐ Madical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner steted. 29a, Certifier (Check only one) 29b. Signeture end title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) 20056319 BALTIMORE, 30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print) GW. MOLINEUX MICHAEL 9105 FRANKLIN SOUARE DR 31931 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32729

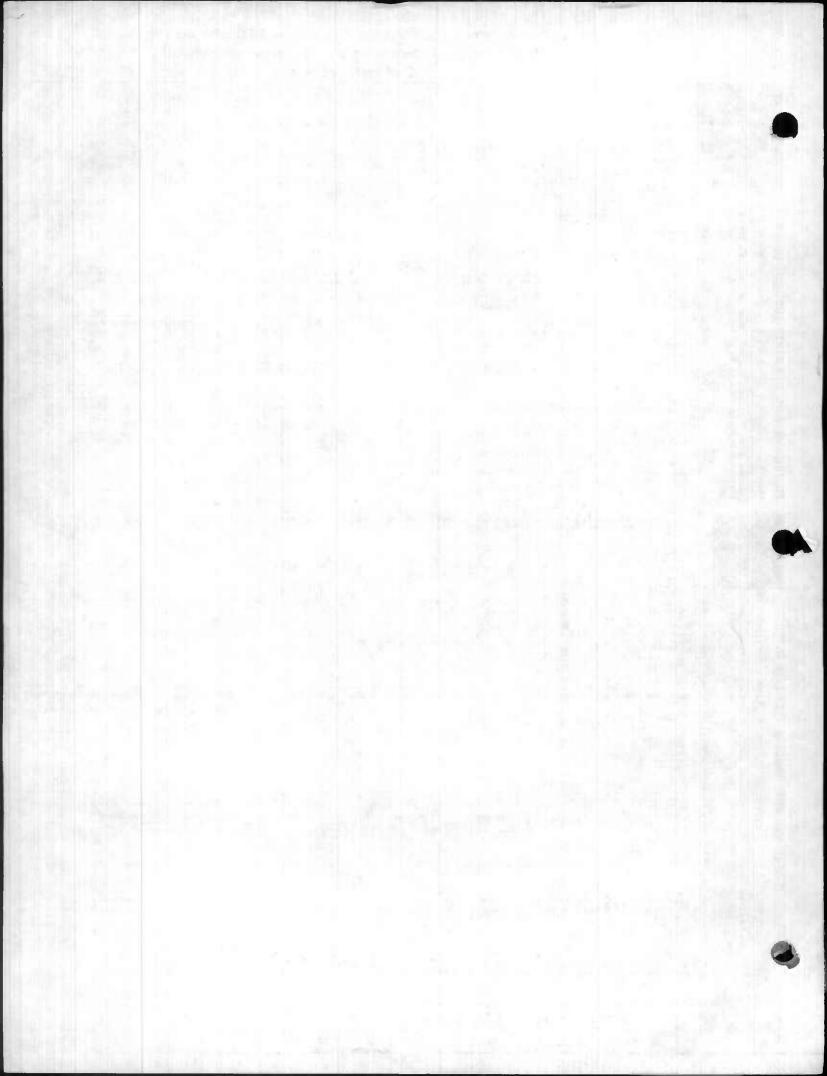
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/Medical Examiner	4.0	Fecility Name (If not institution, give		ΑΛ		4b. City, Town, or Loc		4c. County		V P·III.					
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mil. Pages 1 and instruent of Health octant: if fleen 27-1 injury or other fires.		LILLIANA PASLAWSKYJ/ DAUGHTER 13 LYONSVILLE ROAD, BOONTON, NEW JERSEY 07005													
	20	LILLIANA PASLAWSKYJ / DAUGHTER   13 LYONSVILLE ROAD, BOONTON, NEW JERSEY 07005  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, Stata													
		4 Donation 5 Other (Specification )		ST. MICH	AFI IS IIKT	PATNITAN 10	112/00 1	RAITTMO1	OF MAR	VIAND					
	21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility														
Depart of the part		LILLY & ZEILER INC. FUNERAL HOME 1901 FASTERN AVENUE, BALTIMORE, MARYLAND 212													
N	23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tellure. List only one ceuse on each line.														
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	. 11			Hesp	- The state of the	Balti					N/A				
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21215-0020 d within 72 hours after de	at, or then Examiner. by Fun	11. Marital Status 1 Nevar Mari 3 Widowed	ried 2 Married	12. Was Deced Armed Forc 1 Yas 2 If Yas, Giva Yaar or Date	as? <b>X</b> ] No		Vas Decedent of Yas, specify Cu ☐ Yes 2 No		n? (Specify Y. Puarto Rican,	as or No- atc.)	14. Raca - American Indian, Black, Whita, atc.  Specify: WHITE				
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ita ien:	s certificate director, pag To Be Co	25. Was casa rafai	rred to medical					26. Placa	of Deeth (Che	ck only one)					
of Vita	00	1 □ Yas 2 🖾		Hospitel: 1 Zing		Outpatient	3LI DOA		sing Homa 5				)		
	Wither thunered lon:	27. Manner of Deal	5 Pending		Injury Day Year) 28t	o. Tima of Injury	28c. In W	jury at /ork? □ Yas 2 □ N		ascribe how	injury occurr	ed			
2 3	250 5	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicida	invastigatio	28a. Pleca o	f Injury - At home, J. atc. (Specify)	, larm, stre			28f. Lo	ocation (Strae ity or Town, S		er or Rura	Routa Number,		
Hospital	within 24 hours a To the Funeral D Completely filled i Medical Ce	29a. Certifier (Check only one)	15 Certifying Pl	nysician: To the be miner: On the bas and manna	is of axamination	iga, daath and/or inv	occurred at tha astigation, in my	tima, data and opinion, daath	placa, and du occurred at t	e to tha caus ha tima, data	sa(s) and mai and placa, a	nnar as stand due to	ated. the cause(s)		
o the	Me Within	29b. Signatura and	title of partition		1		29c. Lice	nsa number		29d.	Data signed	(Month, E	Day, Year)		
5	1	1	1/ >	01	154M	A		0139	88	10	1/12/	2000			
(	5/2	30. Nama and add	rass of person who	complated causa			Print) OF MD HO			- GREE			201		
13	State Registrar	31. Date filed (Mor	oth, Day, Year)		gistrar's Signature	_		a ·				44.4			

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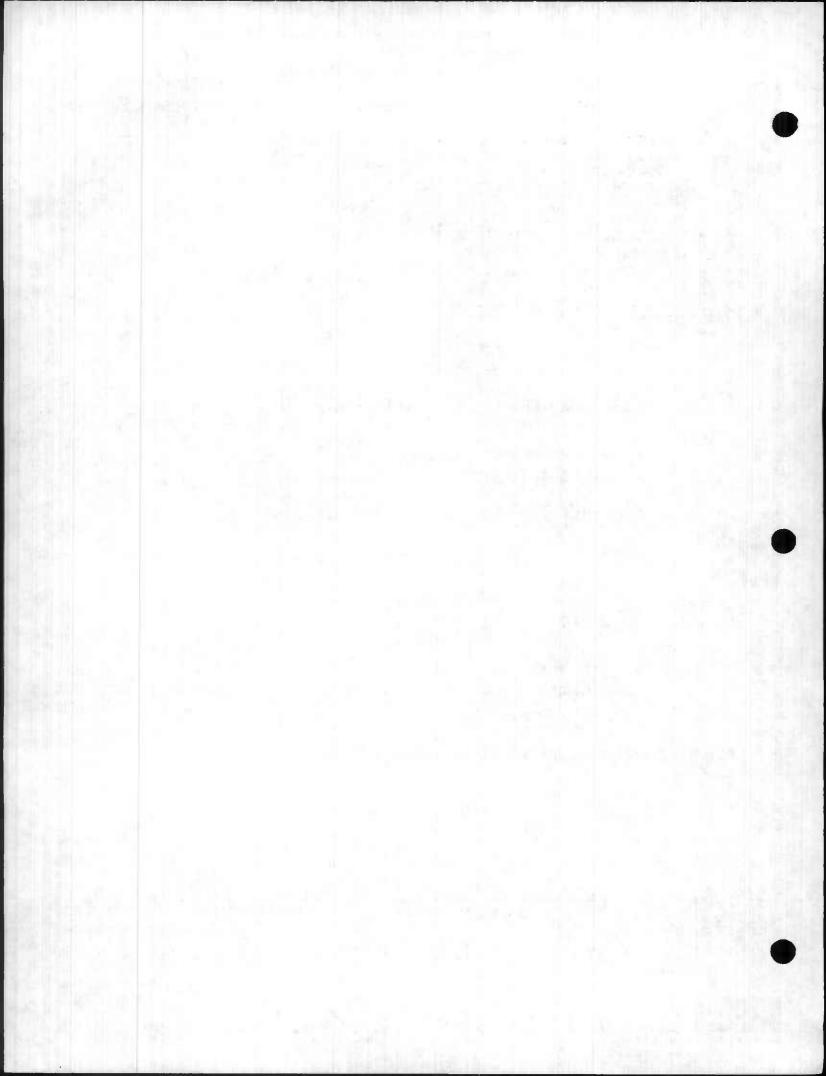


#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene (1000)

				ar y raina /	Certificat		Death	Re	g. No.	0	2/3/	
	Physician	1. Decedent's Name (First, Middle, Last) PERRY SIEGEL					2. Dete of Deeth  Month  OCTOBER 15, 2000				3. Time of Death	
	/Medical Examiner	4a Facility Name (If not institution, give street and number)			SIEGEL	4b. City, Town, or			4c. County		8:40 AM	
	Evaluate Director Director	GENESIS ELDERCARE RANDALLSTOWN				RANDALLSTOWN			BALTIMORE			
		5. Social Security Number 6. Sex 1 M M 2 🗆		7. Age (In yrs. lest birthdey)  Yrs.  1				rs. 8. Dete of Birth (Month, Dey, Year) 9. Bir (APR • 22, 1909			ece (Stete or Foreign try) MD	
		Usual Residence of Decedent  10a. State 10b. County	vn or Location	or Location 10d. Inside City Limits								
		MD N/A BAI			LTIMORE				1½ Yes 2□No			
		10e. Street and Number 2903 FALLSTAFF ROAD #308			10f. Zip Code			10	g. Citizen of W		ry?	
Maryland 21215-0020	for death w r terms 23s siner mat.			12. Was Decedent Ever in U.S.		21209  13. Was Decedent of Hispenic Origin? If Yes, specify Cuban, Mexican, Pue			U.S.A.  14. Race - American Indien,			
	ar, or han Examiner.	11. Maritel Stetus  1 □ Never Merried 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent E  Armed Forces?  1 □ Yes 2 ☒ ☒ M  H Yes, Give  Yeer or Detes:						Black, White, etc.  Specify: WHITE				
	72 ho matum disal	15. Deceden (Specify only higher				6a. Decedent's Usuel Occupation (Give kind of work done during most of w		ing 1	6b. Kind of Business/Industry			
	ed within 72 ho ygiens. ser than "natur it, the Medical. Completed	Elementery/Secondery (0-12)	Cotlege (1-4or		iite. DO NOT use retired) MERCHANT		od)		RETAIL			
	al Hyginal Hyginal A other wealt, I	17. Father's Neme (First, Middle, Last)			24 (012) 24 (2		18. Mother's Name	ame (First, Middle, Maiden Surneme)				
	Menta Menta Menta Menta Menta To E	MAX		SI			SARA	FEINBERG				
Mar	12 sh h and h and he ma	19e. Informent's Name/Relations BERTHA SIEGEL					t end Number or Run		-			
	Health Health Hem 27 Other to	20e. Method of Disposition	/ WIFE	2903 FALLSTAFF ROAD #				Date 20c. Location - City or Town, State				
omi	Page nati II I ny or	1  Burial 2  □ Cremation 4  □ Donation 5  □ Other (S			gry, cremetory or c GTON CHI		210020	0/16/00	BALT	IMORE	, MD	
Baltimore	Departri Departri Importa any Info	21. Signature of Funeral Service Monage 22. Name and Address of Facility					ess of Facility	SOL LEVINSON & BROS., INC.				
		23a. Per Chiar the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between										
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	ATH	a. ATHEMOSCIENATIC CANDIO MSCUCANDS YES  Due to (or es a consequence of):								
0,	certificate be executed rding physician end use as the buriel-transit n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury	<b>6</b>	b								
x 68760		that initiated events resulting in deeth) Lest	c	c								
Box	deeth certif e attending ed for use a	Part II Other elgoificent condition	une contributing to death h	contribution to death but not resulting in the undertring gauge gives in Part I				23b. Did tobacco use contribute to the cause of death?				
P.O.	es that the deeth cert igned by the attendin be detached for use by Physician/W	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.  DEMENITIA					ven in Faiti.	1 Yes 2 No 3 Probably				
Records,	The law requires that the deeth cardial sate has been signed by the attending page 2 should be detached for use.  Completed by Physician/M	CHANIC CUNG			DIVEASE			24a. Was ar perform	autopsy led?	ava	ere eutopsy findings ailable prior to mpletion of cause death?	
	The Late he page							1 ☐ Ye	s 20 No	10	Yes TNO	
of Vital	slan: entific ector	25. Was case referred to medica examiner?	Hospital:	26. Plece of Deeth (Check only one)  Hospitel: Other: Garage of Deeth (Check only one)								
	£ 5 5	1 Yes 210 No	28a. Dete of Injury 28b. Time of 28c. Injury at				4 Nursing Ho	g Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred				
ion	Attending P of death.  Sector: After by the funer iffication:	Naturel 5 Pendir		y Year)			ork? ] Yes 2 No					
Division	Patra F	3 Suicide 6 Could 4 Homicide determ	ined 286. Place of In					28f. Location (Street end Number or Rural Route Number, City or Town, State)				
	he Hospital he Funeral pletely filled edical C	29e. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) and manner as steted.  Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner steted.										
	To the within 2 to the comple									Day, Year)		
	7	14/14/10/00/11/ 120333 10/16/01										
	0	30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)  K. D. ZON (F) MD 1434 GMGSNTM FR RD PINCHULL										
	State	31. Date filed (Month, Day, Year)	32. Registi	rar's Signature	, 4	/	:	-17/10			MUZPA	

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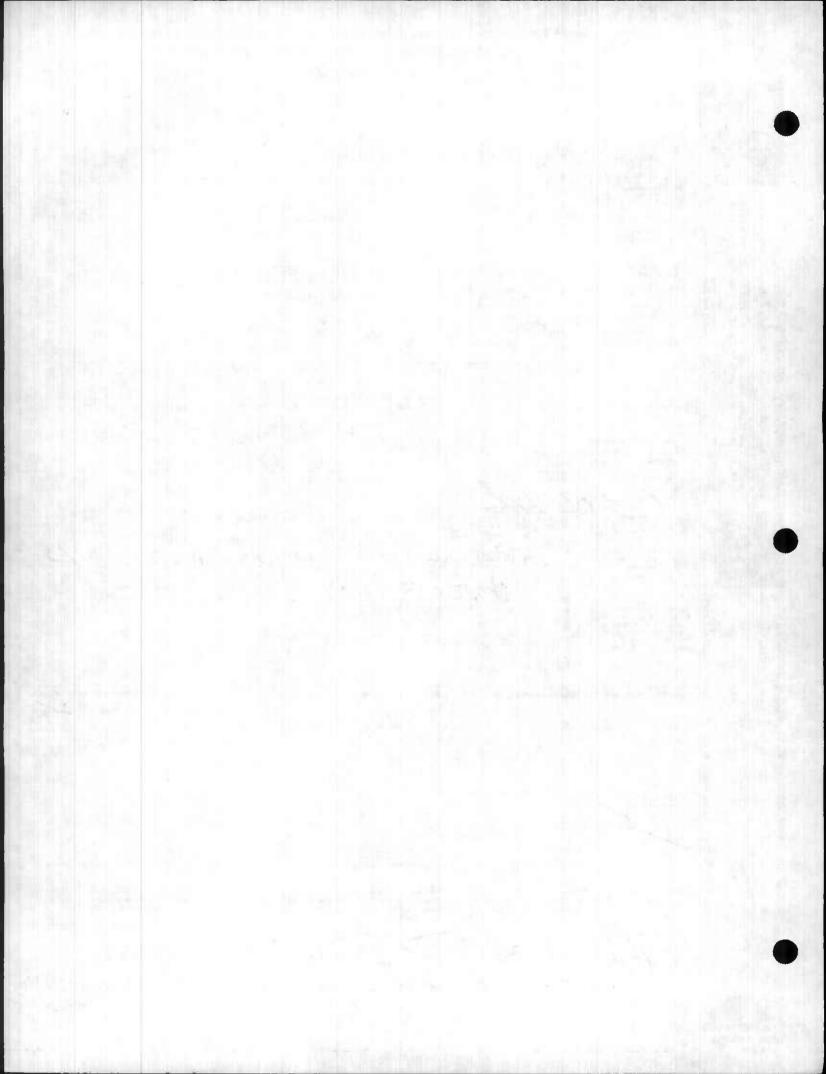
#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Virginia Maxine Taylor October 11, 2000 11:00 am /Medical 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Glen Burnie
| If Under 24 Hrs. | 8. D.
| Hours | Min. | (A Mariner Health of Glen Burnie Anne Arundel If Under 1 Year 5. Social Security Number 8. Dete of Birth (Month, Day, Year) 9. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 2MF Months Days 79 Yrs. Director 220-34-7001 Pa 1-1-21 Usuat Residence of Decedent 10c. City, Town or Location 10a State 10h Counts 10d. Inside City Limits Baltimore Sparks Glencoe 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itama 23a or 2401 String Town Rd. Apt. G3 U.S.A. 21152 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give X Yeer or Detes: 1 Never Married 2 Married 8 Maryland 21215-0020 1 Yes 2 No Specify.White by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 10th 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be 8 Wesley Edith Unknown 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) - 80 Ge Sparks Glencoe of of Health: James Taylor 2401 String Town Rd. Apt. (Son) Baltimore, 20c. Location - City or Town, State 20b. Pieca of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Balto./Wash. Crem. 10-16 Laurel, Md. 22. Name end Address of Facility 21. Signature of Europral Service Licensee Charles Zeiler Funeral Home, Inc. 6224 Eastern Ave. Balto. MD. 21224 tenter the mode of dying, such as cardiac or respiratory arrest, chication that caused the death. Do not en Approximate Intervel Between Onset end Death 23a. Part 1. Enter the disease, or com-shock, or heart feilure. List only Physician ATHENOSAENOTIC CANDIONASCULAN Immediate Cause (Finet disease or condition resulting in death) /Medical **Examiner** Examine Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last the death certificate be axecu Box 68760. Physician/Medicai Due to (or es e consequence of): Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. Division of Vital Records. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown The law requires that Completed by 8 24b. Were autopsy tindings evaileble prior to completion of cause of death? 24a. Wes en eutopsy performed? director, page 2 should this certificate has 2 1 No 1 Yes 1 Yas 2 No 25. Wes case reterred to medicat examiner? Be 26. Plece of Deeth (Check only one) Hospitat: 1 npatient 2 FR/Outpatient 3 DOA Other: 4 Nersing Home 5 Residence 6 Other (Specify) 10 1 Yes 2D No 28c. Injury et Work? 27. Manner of Beatl 28b. Time of 28d. Describe how injury occurred Certification: f Director: After to in by the funeral Attending or death. 1 DiNatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide or after To the Hospital
within 24 hours a
To the Funeral E
completely filled edicai Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end pleca, and due to the cause(s) and menner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier nd address of person who completed cause of death (Item 23e) (Type, Print) CONICE 30 32. Registrer's Signeture 31. Dete filed (Month, Day, Year) State Conscient. Registrar 1 7 2000

**ORIGINAL** 



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Vaughn, Jr. 11:50 AM Johnnie Ictober 14,2000 4c. County of Deeth 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death City Age (In yrs. last birthday) General NA If Under 1 If Under 24 Hrs. 8. Dete of Birth Month Day, Year 05-06-43 5. Sociel Security Number Birthplace (State or Foreign Country) Months Deys Hours 1 M 2□ F 57 Yrs. 238-70-2490 NC Usuel Residenca of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Prince George Capital Heights MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 USA 316 Possum Court Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes ANO If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: Specify 3 ☐ Widowed ★ Divorced Black Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fencing worker company 9th Grade 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Ellen C. Powell Johnnie L. Vaughn, Sr. 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20744 19e. Informant's Neme/Reletionship (Type, Print) 1004 Spring Valley Court Ft. Washington, MD Ellen M. Gaines 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetery or other plece) Dete 20c. Location - City or Town, Stete 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Powell Family Cem. 10-21-2000 Conway, NC 21. Signature of Funeral Service L 22. Neme end Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue promitions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, 23a Part1. Enter the disease shock or heart failure Immediate Cause (Finel Spiration Preumon diseese or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequença of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Mengef of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending Investigation

**Physician** /Medical **Examiner** The law requires that the death certificate be executed

physician

8

**Physician** 

/Medical

Examiner

Directo

Funeral

Be

**Funeral** 

Director

or 28a-1

herns 23a

8 marked

Pages 1 and 2

altimore,

Box 68760.

P.O.

Division of Vital Records.

Attending Physician:

Examiner the buriel-transit Physician/Medical use as p Be

Completed Certification: To

detached been signed by should be detact certificate funeral director, this After after death.
Director: A death. To the Hospital or A within 24 hours after To the Funeral Directon pletely filled in b.

State Registrar

Medical

mastern 30. Neme and address of parson who completed cause of deeth (Item 23a) (Typa, Print) George

29b. Signeture end title of certifié

6 Could not be

OCT 17

1 Neturel

2 Accident

3 ☐ SuicIde

29a. Certifier (Check only one)

4 Homicide

m.D. 90 31. Date filed (Month, Dey, Year)

32. Registrer's Signeture

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

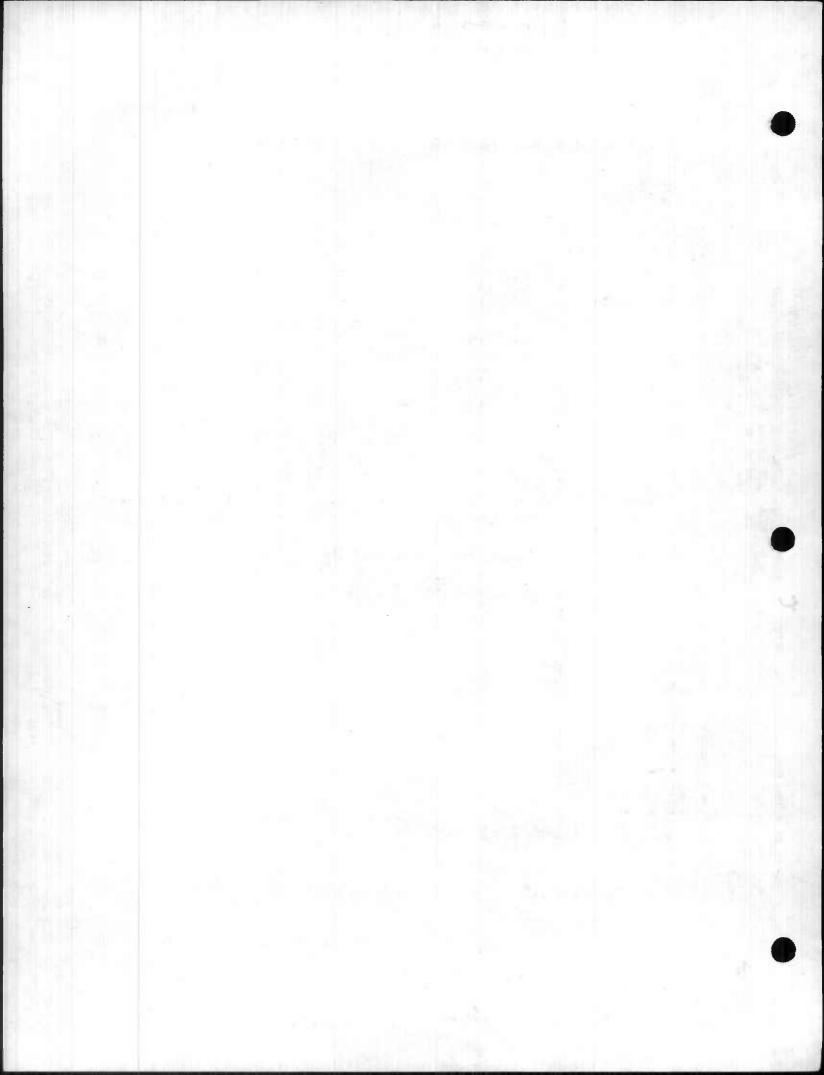
29d. Date signed (Month, Day, Year)

00

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner steted.

29c. License number



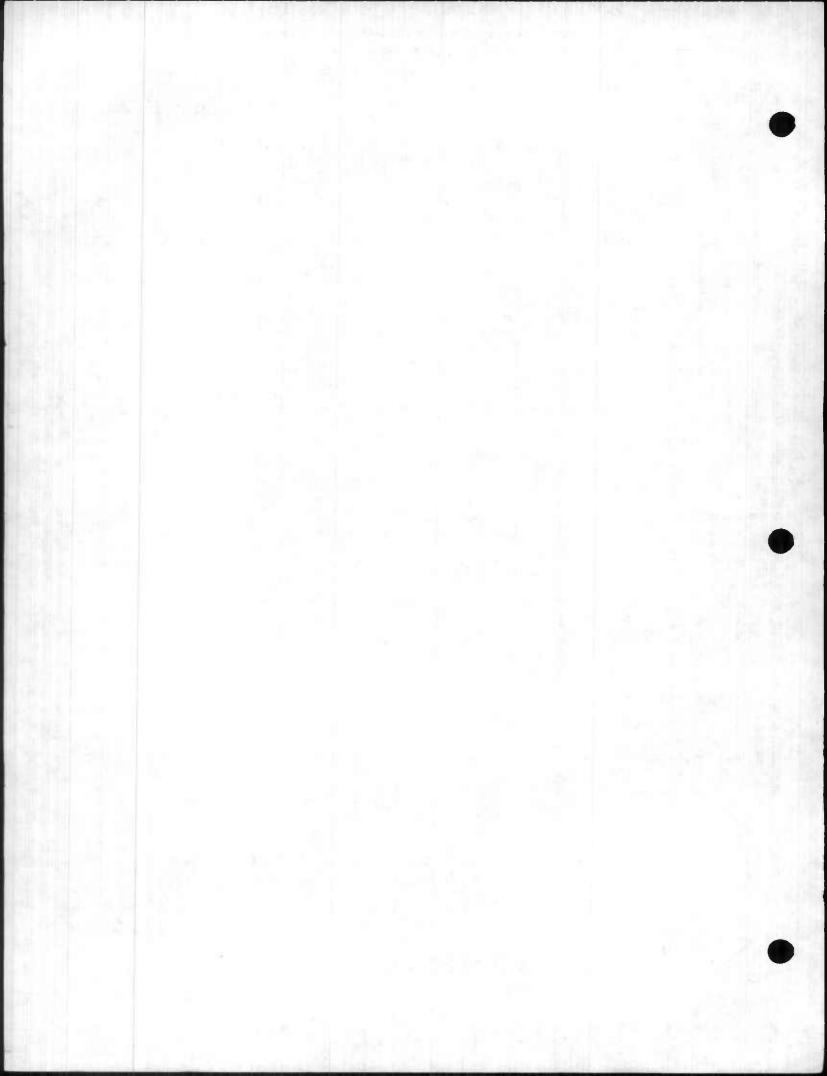
#### Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Deeth 3 Time of Death Month Year 2000 **Physician** VIRGIL WHITE 10:15 AT octobe /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sivai Baltimore 5al hune Hours Min. APR. 1,1913 If Undar 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** Deys 10 M 20 F 87 249 18 7511 SOUTH Carolin Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or flems 23e or 28e-f show officel Examiner must be notified at 1 Yas 2 No MD. N/A Director BALTIMORE Patient kunon as: White 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4800 SETON DRIVE OF 21215 U.S Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Merital Stetus 1 Yes 2 No If Yes, Give Yaar or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind ot Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) UNKNOWN UNKNOWN RACE HORSE GROOM RACE TRACK 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Sumama) Be TOM WHITE MINNIE BROWN 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21784 19a. Intermant's Name/Relationship (TypePMVGHTER \* Department of Health Important: If Nem 27 7200 THIRD AVENUE APT. A101 SYKESVILLE, MD. Lu Virgiline stevenson 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cramation 3 ☐ Removal from State MT.ZÍON CEMETERY 10/18/2000BALTIMORE, MARYLAND 4 □ Donation 5 □ Other (Specify) GWYNN22, Name and Address of Facility LEWIS T. GWYNN FUNERAL HOME 21215-6494 21. Signature of Foregral Service Licansee LEWIS Teva 4517 PARK HEIGHTS AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate tnterval Between Onsat and Death Physician /Medical tmmediate Ceuse (Final diseese or condition resulting in death) Examiner Due to (or as a consequence of) Examiner burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting to death) Last and Due to (or as a consequence ot): Box 68760 Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributs to the cause of death? the detached 5 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown Division of Vital Records, þ page 2 should be 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy Completed performed? certificate has 2 No 1 ☐ Yes 1 ☐ Yes 2 ☑ No 25. Was case reterred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No To 27. Manner of Death Certification 28b. Tima of 28d. Describe how injury occurred if or Attending P. after death. 1 Natural 5 Pending Injury investigation 1 Yes 2 No 2 Accident Director 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) Placa of Injury - At home, tarm, street, tactory, offica bullding, etc. (Specify) 4 Homicide To the Hospital of american District to the Fameral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 2000 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore W. les 240 31. Date filed (Month, Day, Year) 32. Registrar's Signatura

parka

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DHMH 16 Rev 6/95

State Registrar



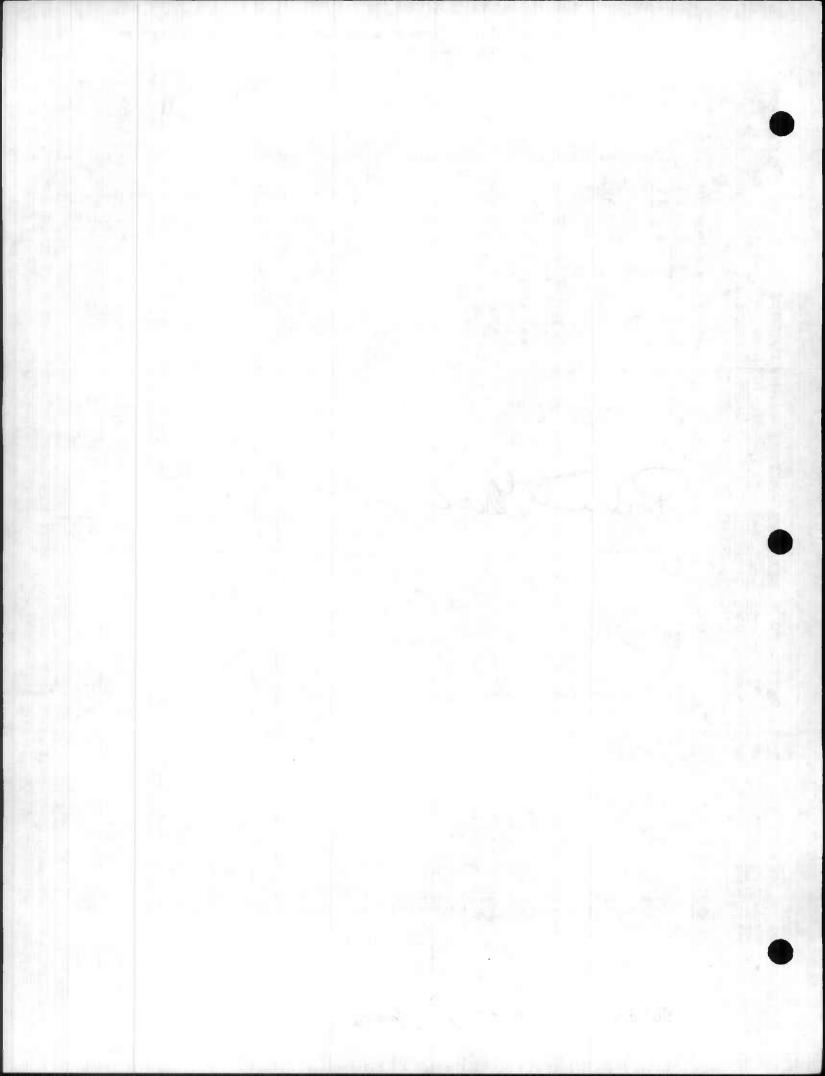
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** 127 Kittie Irene Weller ain ctoper 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 14527 Bain Road Washington Hangocks. If Under 1 Yaar 9. Birthplace (Stata or Foraign Country) 6 Sev 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 214-32-4085 Months Days Hours Min 1 M 2 F Yrs. Director Jan. 18. 1918 Maryland Usual Residence of Decedant 10s State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at MD Washington 1 ☐ Yes 2 No Hancock Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 14527 Bain Road Herrs 23a 21750 U.S.A. Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 11 Marital Status e filed within 72 hours after al Hygiene. other then "natural", or the 1 Never Married 2 X Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ XNo Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Seamstress Garment permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, important: If Item 27 is marked other any Injury or other transfer other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Younker Florence Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger E. Weller/Husband 14527 Bain Road Hancock, MD 21.750 20c. Location - City or Town, Stata 20b Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State Oct. 4 ☐ Donation 5 ☐ Othar (Specify) Stone Bridge Brethren Cemetery 13,2000 Hancock, MD 1. Signature of Funeral Service Do 22. Nama and Address of Facility Grove Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused tha death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only on cause on each line. MD 21750 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disaasa or condition resulting in death) /Medical ears Examiner Examiner Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last pue Due to (or as a consequence of). physicien the burial Box 68760 certificate be edicai Due to (or as a consequence of): 80 the attending Physician/M 950 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? igned by 3 □ Probably 4 □ Unknown 1 Yes 20 No Records, à 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed certificate has page 2 No 1 Yas 1 ☐ Yes 2 ☐ No Division of Vital 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check oply one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home To 1 Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 1 Divatural 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury al Work? or Attending 5 Pending investigation i Director: Aft d in by the fur 1 Yes 2 No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours legipe \* Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 2 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year) 29c. License number Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 36

State Registrar

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32. Registrar's Signature

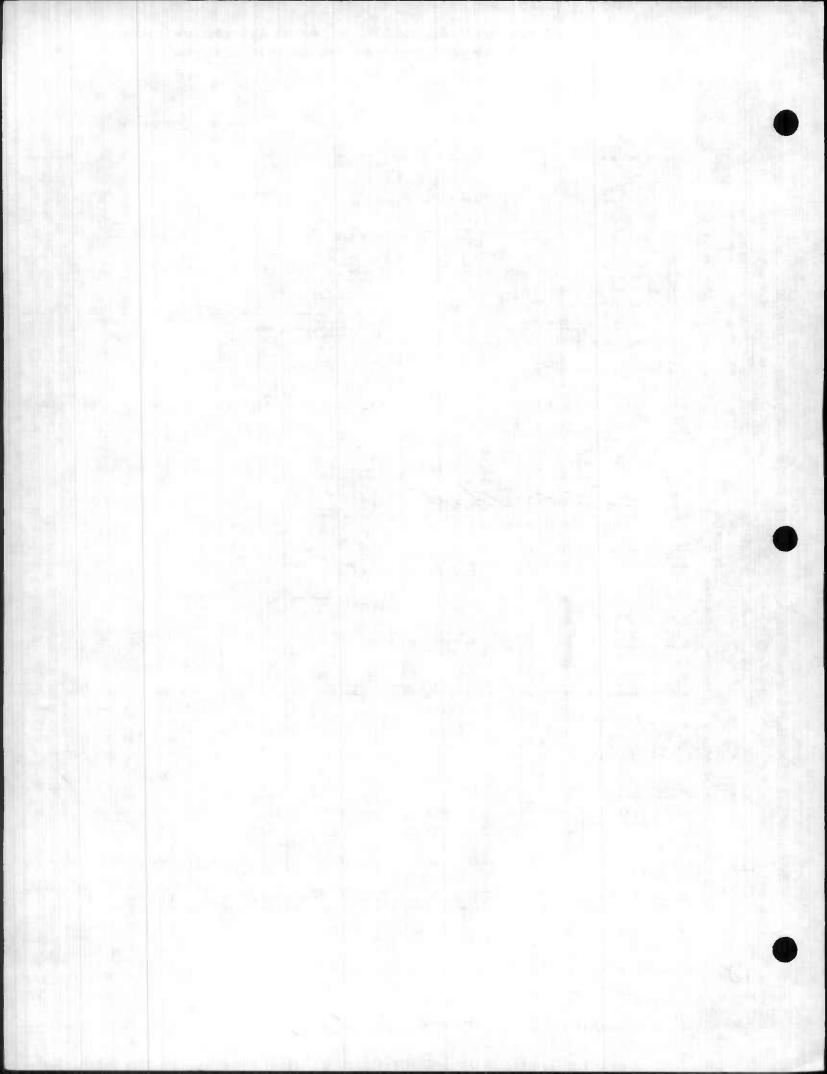


State of Maryland / Department of Health and Mental Hygiene

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	1. Decedent's Name (First, Middle, Last)					NOW PAGE	2. Date of Month		ay	Yeer	3. Time of Death
nysician Medical	HELEN ANNA WASH	IEL					OCT.		2000		6:10 p
xaminer	4a Facility Neme (If not institution, give street en	d number)				4b. City, Town,	or Location of D		c. County		
Administ	JOHNS HOPKINS HOSP	TTAI				BALTI	MORE		N/A		
	5. Social Security Number 6. Sex	7. Age (In yrs. I	last birthdey)	If Und	er 1 Year	If Under 24		Birth Dey, Yea			ece (State or Foreigny)
neral ector	212-34-8436 1DM 21		Yrs.	Month	Deys	Hours I		16.1		MARY	
ECTO	Usual Residence of Decedent	00					Juli.	10,1	734	MAKYI	LAND
	10a. Stete 10b. County	10c. City	, Town or Lo	cation						10	d. Inside City Limit
P 5	110	-									1 Yes 2□N
be notified Director	MD. N/A BALTIMORE  10e. Street and Number 10g. Citizen							Pielman of M	What Caust	-2	
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r must be notified at neral Director	102 S. WASHINGTON STR				1231				u.s.		
iner must	Arme	Decedent Ever in U, ad Forces?	S. 13. \	Was Dec	edent of hecify Cub	lispanic Origin' en, Mexican, P	? (Specify Yes of uerto Rican, etc.	No-		e - America k, White, e	
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D V	3 Widowed 4 Divorced Year	or Detes:							Оровну	WHI	ΓΕ
t, the Medical	15. Decedent'a Education (Specify only highest grade comple	rtad)	16a. Deced	dent's Us	uel Occup	ation	working	16b.	Kind of Bu	usiness/Indi	ustry
Mad pld		ege (1-4or 5+)	life. I	DO NOT	use retire	during most of d)	Working				
at no	12		COUR	T CL	ERK			MD.	STAT	TE GOL	VERNMENT
Be C	17. Father's Name (First, Middle, Last)			47.		18. Mother's	Neme (First, Mic				
0 0	WALTER DYLEWSKI					HARG	ARET C.	RFFS	F		
F	19e. Informant's Name/Reletionship (Type, Print	)	19h Mailie	nn Addro	ss (Street		r Rural Route No			State Zin	Code)
	ROBERT WASHEL / HUSBAND		lece of Dispo			GIUN SI	REET, BA.				
	20a. Method of Disposition  1 □YBurial 2 □ Cremetion 3 □ Removel	0	emetery, crer	netory of	other pla	ce)	Date	200.	Location -	City or Tov	vn, State
	4 ☐ Donetion 5 ☐ Other (Specify)	The second secon	DOWRID	GE N	IEM.	PARK 10	/18/00	EL	KRIDO	GE, MAI	RYLAND
4	21. Signeture of Funerel Service Licensee	1	22	. Name	end Addre	ss of Fecility					
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	22a Part Leter the disease or complications	that agued the doot	Do not not	901	EAST	EKN AVE	NUE, BAL	LIAUK	E, MAH		Approximete
	23a. Part1. Enter the diseese, or complications shock, or heart tailure. List only one cause	on each line.	00 1101 0111	0. 0.0			olog of toophoto	, ,			Intervel Between Onset end Death
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ner	Immediate Cause (Final disease or condition resulting in deeth)	oronan	1 a	16	en	Liser	re			10	days
	resulting in deetin)	Due to (e	es e consec	quenca o	f):						
Examiner										d and	
E	Sequentially list conditions,	Due to (or	r es e conseq	ineuce o	f):						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury									1	
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ledical Examir	resulting in death) Last		200								
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Physician	Pert II. Other eignificant conditions contributing	to death but not resu	uning in the u	naertying	cause gi	ven in Part I.				14	the cause of deat
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pie	The state of the s					31 10					leath?
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	25. Was case referred to medical					26 Place of	Deeth (Check o	- 572		1	
o Be	examiner?	1 Discoulant SM	ED/0.4*	4 00	Oti	ner-			e 🗆 🗆	ne (C*	.)
_  -	TLI Tes 214 No	1 ☐ Inpatient 2/20 Date of Injury	ER/Outpatier 28b. Time of	_	DOA	4 LI Nursi	ng Home 5 1				1
0	1 Neturel 5 □ Pending	(Month, Day Year)	Injury		28c. Inju Wo		200. 2000	.50 1.011	, , , , , , , , , , , , , , , , , , , ,		
Certification:	2 Accident investigation 3 Suicide 6 Could not be			М		Yes 2 □ No		(0:			10-4-14
=	determined 200.	Plece of Injury - At ho building, etc. (Specif)	ome, ferm, str	eet, fect	ory, office			on (Street Town, St		oer or Hurai	Route Number,
Ç											
	29a. Certifier 10 Certifying Physician: T										
edical	(Check only 2 Medical Examiner: On i	the basis of examinat menner stated.	tion end/or in	vestigation	on, in my o	opinion, death	occurred et the ti	me, date a	ind place,	and due to	the ceuse(s)
Z	29b. Signature and title of certifier	2		2	9c. Licens	se number		29d. (	Dete signe	d (Month, L	Dey, Year)
	Ph. Alic Che	MO			1-	1815-1	/	,	n-1	6-0	2
/	7 - 7 - 7				-0	1013		1/	/ /	, ,	
	30. Name and eddress of person who completed	cause of death (Item	23a) (Type,	Print)							
	CHI-SHIANG CHEN, M.D.	301 ST. P	AUL PI	ACE	SUIT	E 409. E	BALTIMOR	E. MAR	YLANI	0 212	02
State		32. Registrer's Signe		,							
Julie											

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Deeth 3. Time of Death Month

Glen Burnie

4b. City, Town, or Location of Death

October 14,

200

Anne Arundel

4c. County of Death

MD 21060.

GLENBURNIE

9:20

10d. Inside City Limits 1 Yes XIX No

Physician
/Medical
Examiner

4e Fecility Neme (If not institution, give street end number)

1. Decedent's Neme (First, Middle, Last)

Frederick J. Wetzel, Sr.

1409 Gordon Drive

**Physician** /Medical **Examiner** Box P.O. Records, of Vital Division or Attending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun

If Under 1 Yaar | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yo 3/4/1926 9. Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Deys Hours 1**XX**M 2□ F Yrs. 74 Director 212-28-7814 Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location MD Glen Burnie Anne Arundel notifie Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? mant be n Вета 23а 1409 Gordon Drive 21061 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 1XXes 2 No If Yes, Giva Year or Detes: 1 Never Married 200 Married Baltimore, Maryland 21215-0020 b 1 ☐ Yes 2 XX No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hy. Department of Health and Mertial Hygiene. Important: If item 27 is merked other than "nature any injury or other traumstic event, the Medical. RDSS. Completed 18a. Decedent's Usual Occupation
(Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Etementery/Secondery (0-12) Cottege (1-4or 5+) Steel Worker Kaiser Aluminum 12 17. Father's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Norman H. Wetzel Rosalia Hardagen 19a. Informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Freed - Daughter 806 Paradise Lane, Glen Burnie, MD 21061 20b. Place of Disposition (Name of cametery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State WBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 10/18 Loudon Park Cem. Baltimore, MD 21. Signature of Funeral Service Licensee FINK FUNERAL HOME, PA 22. Name end Address of Fecility 426 Crain Hwy., SW, Glen Burnie, MD 21061 23a. Part1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) CARDIO RESPIRATORY ARREST Due to (or es e consequence of): Physician/Medical Examiner ADENOCARCINOMA METASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequenca of): that initiated events resulting in death) Last Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. AROTO ARTERY DISEASE by 24a. Wes en eutopsy performed? Be Completed VLCER DISEASE 1 Yes 2 No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yes 2 No 27. Manner of Death 28a. Dete of tnjury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturel 1 Yes 2 No

Approximete Interval Betwe Onset end Deeth DAYS TOFTHE LIVER 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Homa 5 Desidence 8 Other (Specify) Medical Certification: To 5 Pending Investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide Ptece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Caritying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29c. Licansa number 29b. Signetura and title of certifier D52488 ▶ @ Wan magan

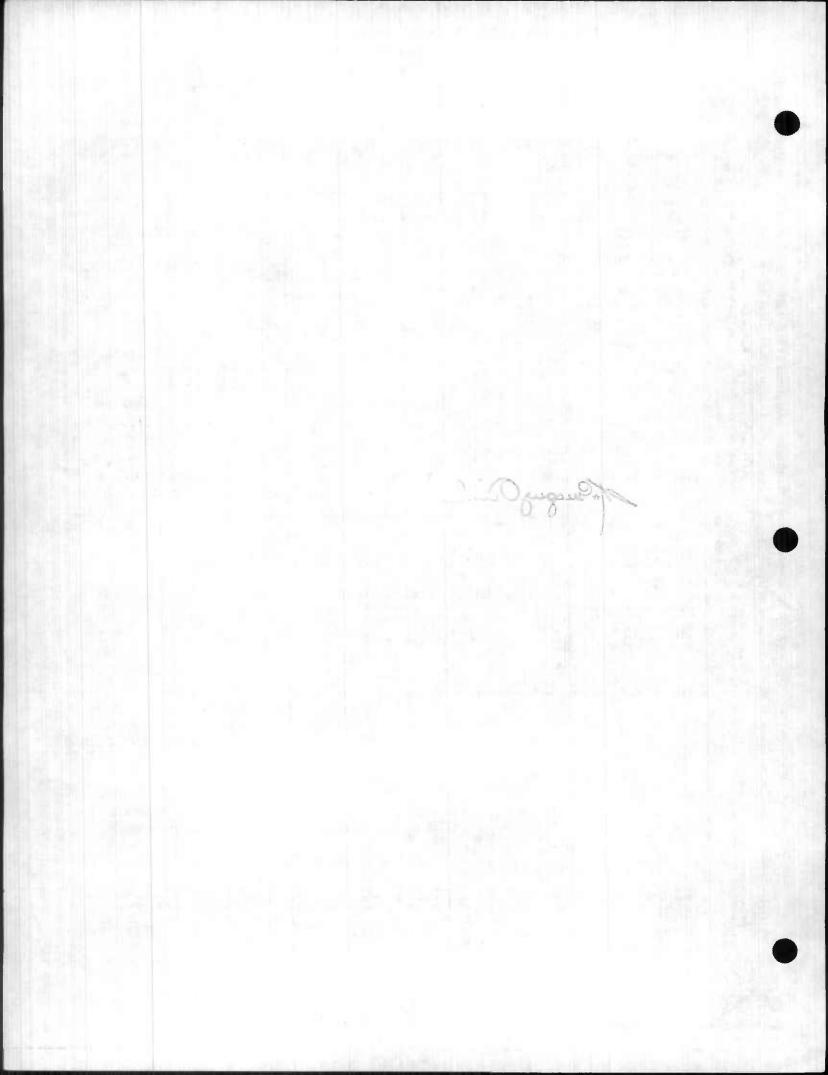
Registrar

DHMH 16 Rsv 6/95

31. Dete filed (Month, Dey, Year) State

32. Registrer's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RAMASNAMY I RANGARATON 7445 FURNACE BROKES RO



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Tima ot Death Day Year Month Physician EVERETT WHALEN SR. Ocotber 12 2000 2120 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL WASHINGTON PRINCE GEORGE'S If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Dey, Year) If Under 1 Yeer 6. Sex XXM 2□ F 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Deys Months Director 42 MAY 4 1958 MARYLAND 216-74-5399 Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inaide City Limits items 23a or 28a-f show 1 ☐ Yes 2√XNo Directo MARYLAND PRINCE GEORGE'S FORESTVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3503 FORREST EDGE RD SOUTH 20747 fal Hygiene. ed other than "natural", or items event, ma Medical Examination Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Black, White, etc. 1 Never Married 2 Married 1 Yes 2000 1 Yes 2 No Specify: Specify: BLACK g 3 XWidowed 4 Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade SKILLED LABORER ASPHALT PAVING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Mental marked HENRY A. WHALEN SR. CARRIE A. JORDAN and and 19a. Intermant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) of Health Item 27 I Hilda M. Whalen/ Sister 3503 Forrest Edge Rd. S., Forestville, Md. 20747 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its eny Injury or ot XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 10-19-00 BALTIMORE, MARYLAND 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE Enter the disea ns that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete If only one cause on each line Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical MICRON Examiner Physician/Medical Examir Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence ot): DNEUMOMI melloward Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) TO Yes 20-No 2 28a. Date of Injury (Month, Dey Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Carentural 5 Pending Injury 1 Yes 2 No investigation 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 8 29s. Certifier La certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated Medical dicat Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar 31. Date filed (Month) Day, Year)

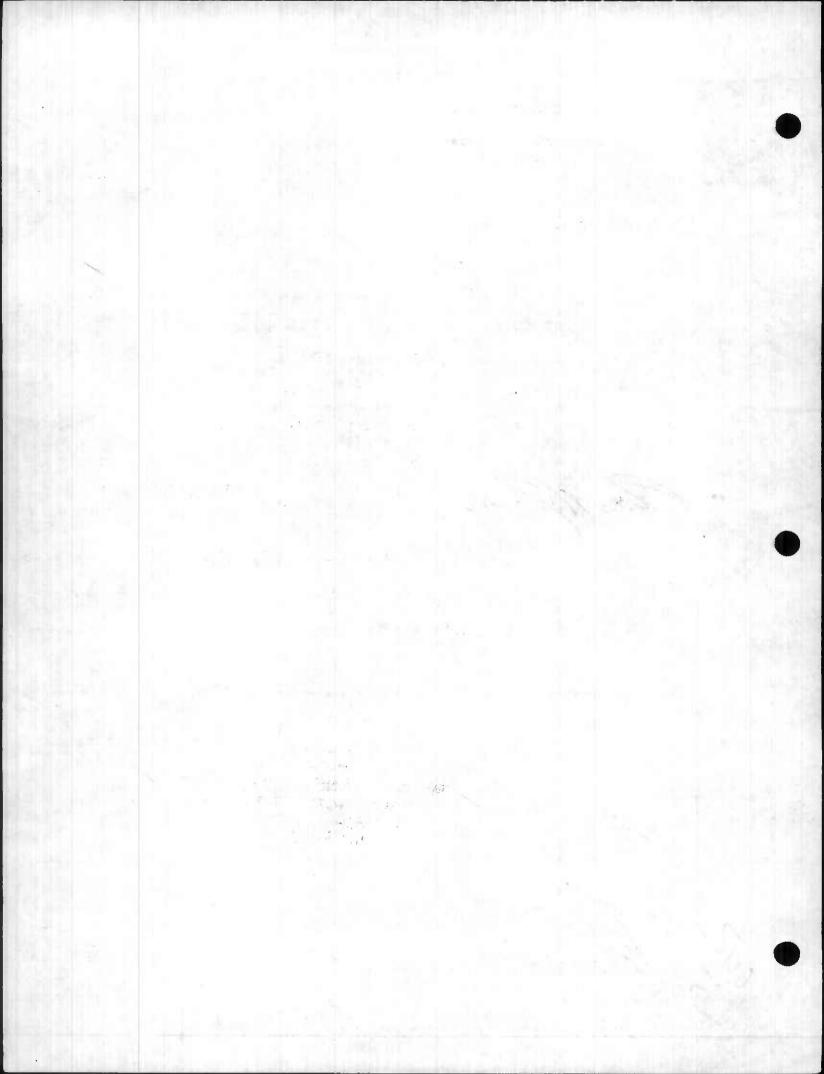
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**DHMH 16 Rev 6/95** 

32. Registrar's Signature

no completed cause of death (Item 23s) (Type, Print)

ston Rd



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Death Month **Physician** Daniel Ashley Youngbar Sr. 2000 1:57 P.M. October 10 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5233 Kramme Avenue Baltimore Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In vrs. last birthday) 8. Data of Birth (Month, Dey, Year) Birthplace (State or Foraign Country) **Funeral** Deys Months Hours 215 64 4303 Director Dec. 19, 1955 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Baltimore Directo 10e. Street and Number 10f. Zip Code 10a. Citizen of Whel Country? U.S. 21225 5233 Kramme Avenue 12. Wes Decedent Evar in U,S.
Armed Forcas?

2☐ Yes 2☐ No 1977If Yes, Giva
Yeer or Detes: 1983 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indian. Black, White, etc. 1 Never Merried 2 Married 1 Yas 2 No Specify: Specify: å 3 ☐ Widowad 4 N Divorced White 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Comple Elementery/Secondery (0-12) Collaga (1-4or 5+) Concrete Company Truck Driver 12th 17. Father's Name (First Middle Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be Delores A. Akers Michael J. Youngbar Sr. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) If them 27 Baltimore, Maryland 21225 5233 Kramme Avenue Daniel Youngbar Jr. Son 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State Glen Haven Memorial Park 10/14/00 Glen Burnie, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 ramiflesh fications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, no ceuse on each line. Approximate Intarvel Between Onsat and Death BIDURN MASS, larger **Physician** Immediate Cause (Finel disease or condition rasulting In deeth) /Medical Examiner Dua to (or as a consequence of): Examiner Stem ed MULTIPLE MUBOWN May Sequentially list conditions, if eny, leading to immediate ceusa. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): edicai Dua to or as a consequence of): STICLO ABJU 10806 Physician/M Pert II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? by Records, 24b. Were eutopsy findings available prior to completion of ceuse of deeth? Completed 24a. Wes en eutopsy performed? 200No 1 Yes 1 ☐ Yes 2 ☐ No. 25. Was casa referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Assidence 6 Other (Specify) 1 ☐ Yas > No 28a. Deta of Injury (Month, Day Year) 28d Describe how injury occurred 27. Mennar of Death 28c. Injury et Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 6 Could not be 3 Suicide 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Speaily) 4 Homicide 1 Certifying Physician: To the best of my knowledga, death occurred at the tima, date and place, and dua to tha cause(s) and menner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daeth occurred at the tima, date and place, and dua to tha cause(s) and menner stated. edical 29a. Cartifier (Check only one) o the v # 29b. Signeture end title of certifiar 29c. License number 29d. Date signed (Month, Day, Year) Michael Leon YW 30. Name and address of person who completed ceusa of deeth (Item 23e) (Type, Print) 4000 Old Ct. Road Suite 203 Balto., MD 21208 Y/A= 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State 1 7 2000

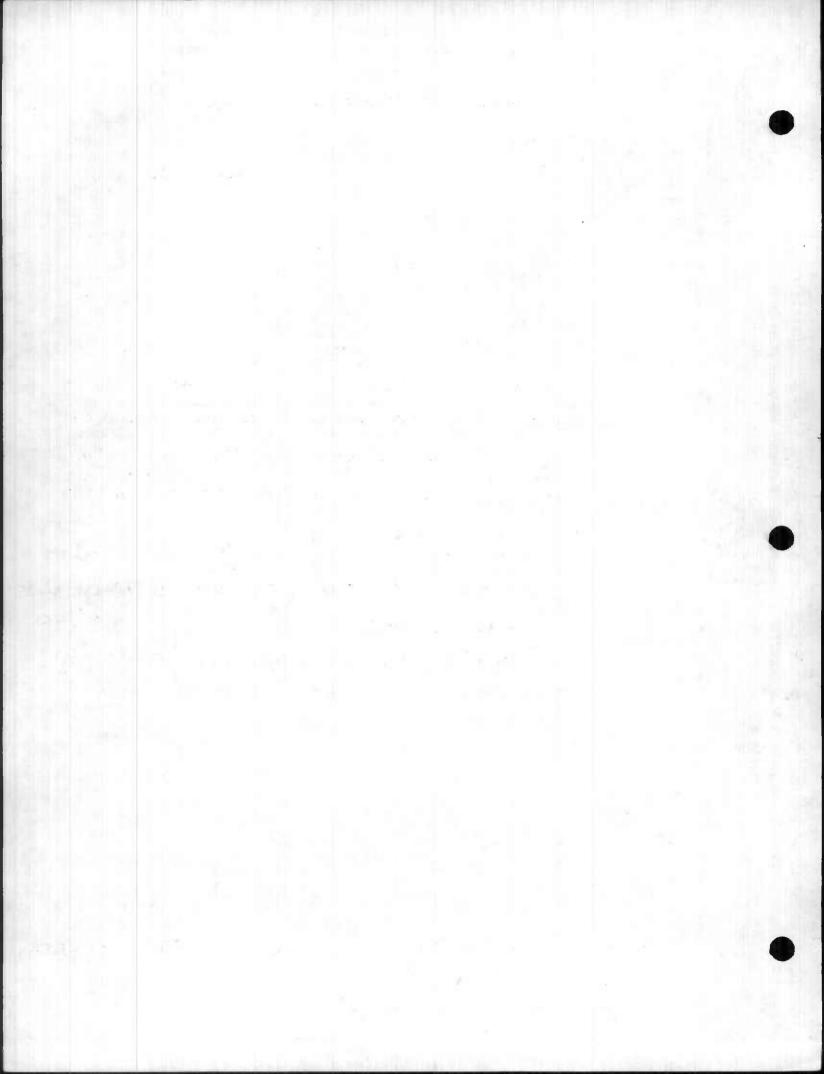
DHMH 16 Rev 6/95

Registrar

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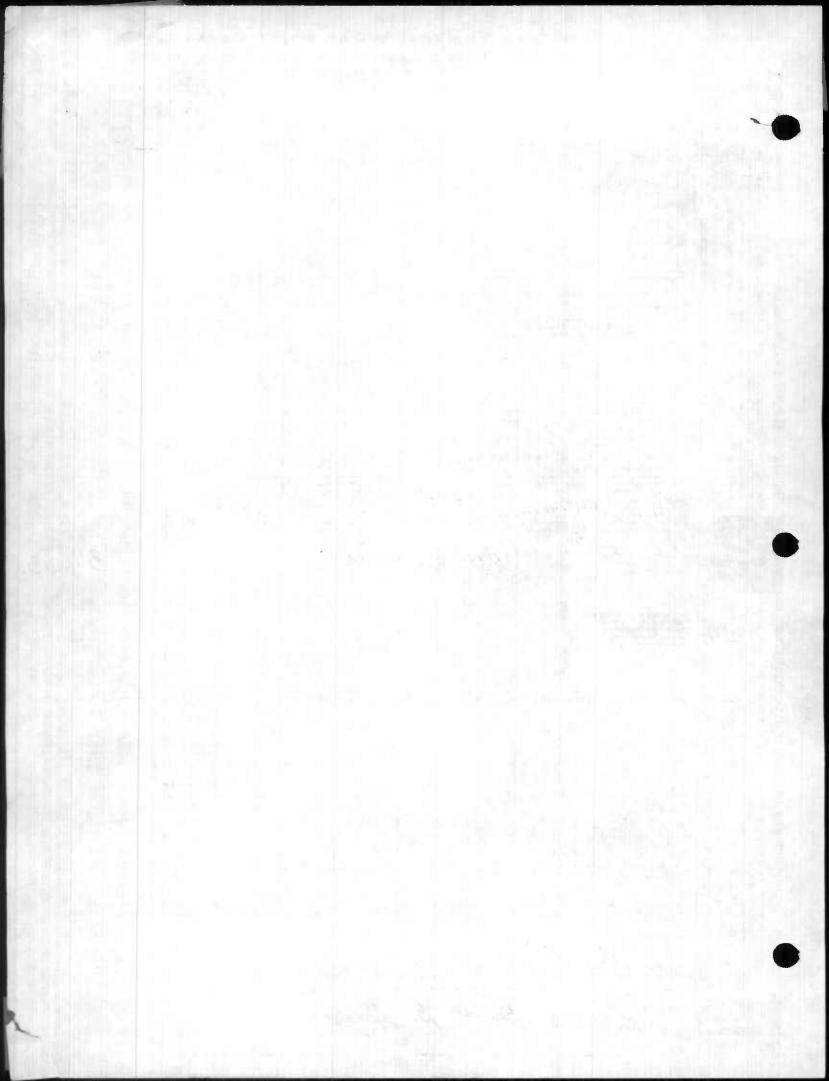
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State of Maryland / Department of Health and Mental Hygiene 00 32740

			Ce	rtificate of	Death		Reg. No.		2140	
Dhuais Tau	1. Decedent's Name (First, Middla, L.	ast)	79			2. Date of De Month		Year	3. Time of Death	
Physician // // // // // // // // // // // // //	JANICE G.	ANDREWS					29,2000	1981	0315	
Examiner	4e Fecility Nama (If not institution, gi	ve street end number)			4b. City, Town, or	Location of Death	4c. County	of Death		
40.0	TALBOT HOSPICE	HOUSE			EAST	ON	TAI	LBOT		
Funeral Director		Sex 1 M 2 M F 62	s. last birthdey) Yrs.	If Under 1 Year Months Deys				9. Birthpl Count MARYI	lece (Stete or Foreign try) LAND	
2	Usuel Residence of Decedent									
a Maryta lant show lifted at	MD 10b. County	LBOT	CORD					10	od. Insida City Limits 1 ☐ Yas 2 🔯 No	
er death with the Marytis Reme 23e or 28e-f sho ner must be notified at 'uneral Director	10e. Street and Number 10708 CHAPEL ROA	.D		101. Zip Code 21	625			10g. Citizen of Whet Country? USA		
O20 or af	3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever In Armed Forces?  1 Yes 2 No If Yes, Give Yeer or Detes:		Wes Decedent of If Yes, specify Cub 1 ☐ Yes 2000No	Hispanic Origin? (! ben, Maxicen, Puel Specify:	Specify Yes or No no Rican, atc.)	- 14. Rec Blee Specify	e - America ck, Whita, e WH	etc.	
1 21215-0020 ed within 72 hours at yoberte per than "naturel", or t, the Medical Exam Completed by 1	15. Decedent's E (Specify only highast gr	rade completed)		dent's Usual Occu	during most of wo	orking	16b. Kind of B	usiness/Ind	ustry	
with the Man	Elementery/Secondery (0-12)	) College (1-4or 5+) REFRESHMENT MANAGER				FRATERNA	AT. ORG	GANIZATION		
	17. Father's Nema (First, Middle, Las.	0	THE ITE	DIMIDIAL 12					JIM EDITE TO	
yland yland Mental H wheel of allo ever						her's Neme (First, Middle, Maiden Sumeme) IE PINDER				
Maryland ind 2 should be file ind 2 should be file infly and Mental hy 27 is merked oth r traumatic event To Be (	19e. Informant's Name/Ralationship ROBERT E. ANDREWS		200.00		ROAD, C				Coda)	
Baltimore, semit. Pages 1:s separtment of Ne mportant: if then my injury or other dock.	20a. Mathod of Disposition  ↑ XBurial 2 ☐ Cremetion 3 [ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	cemetary, cret	osition (Nema of matory or other ple CHURCH C	EMETERY	Data 10-02-20	20c. Location -	City or Tov		
Baltim permit. Pa Department important any injury ance.	21. Signature of Funerel Sarvice Lice		SP FE		ELFENBEI				OME, P.A.	
Physician /Medical	23a. Part1. Enter tha diseese, or con shock, or heert feilure. List only Immediate Cause (Final disaese or condition	one ceuse on each lina.	oth. Do not and	er tha mode of dy	RISON ST ing, such es cardie	ec or respiretory e	N, MD Z.		Approximate Intervel Between Onset end Deeth	
Examiner	resulting in death)	0	(or as e consec					1	J 12415	
. Box 68760, death certificate be executed e attending physicien end ed for use as the bunal-transit	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	or es a consec					1		
P.O. Box lat the deeth cert d by the attending etached for use Physician/M	Part II. Other significant conditions of	dcontributing to death but not re	sulting in the u	nderlying cause gi	van in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death?	
						10	Yes 2 PNo	3 Prob	ably 4 Unknow	
cord requir been s should							an autopsy rmed?	eva	re eutopsy findings illable prior to appletion of cause daath?	
The lever the le						10	res 2 No	10	Yes 2□ No	
Vital Indicional The Contificate rector, pag	25. Wes cese raferred to medical				28. Place of De	eth (Check only o	ne)			
Of Vita Physician: rithis certific and director,	exeminer?	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpetier	nt 3 DOA Ot	her:	Home 5 ☐ Resid		HOSPI	CE HOUSE	
After fune for for	27. Menner of Death  1 Vatural 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju	iny at ork?  Yes 2 No	1	how injury occur		,	
Division (  but or Attending P  ts after deeth.  In Director: After the funer  ed in by the funer  Certification:	3 ☐ Suicide 6 ☐ Could not be datarmined	28e. Pleca of Injury - At the building, atc. (Special	noma, farm, str	eet, factory, offica		28f. Location (3 City or Tox	Street end Numb vn, State)	er or Rure	Route Number,	
Division  To the Hospital or Attend within 24 hours after deet To the Funeral Director: completely filled in by the Medical Certifical	29e. Certifier 1 Certifying Pr (Check only 2 Medicat Examone)	nysician: To the best of my kniner: On the basis of axaminand menner stated.	owledge, deeth ation and/or in	n occurred at the ti vestigation, in my	ma, data and plac opinion, death occ	e, and due to tha urred at tha time,	cause(s) end ma date and placa,	anner as sta and due to	ated. the cause(s)	
Fo the	29b. Signetur and United Striffier			29c. Licen	se number		29d. Data signe			
	1 Otto		NEW.	D39	39887 9/29/00		0			
D. O.	30. Nema and address of person who DAVID H. SMITH, N				STON MD	21601				
State	31. Date filed (Month, Day, Year)	32. Registrer's Sign				21001				
Registrar	OCT 0 2 2000	The state of the s	10.	Spark						

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #26,10/3/2000, BMW, Montg. Co. Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death Month COOKS **Physician** MATOKA JAMES AUTEMUS 0930 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner GATHOUSBULG 12224 GOLGEVILLE PORC MONTOON BLY If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days Months Hours 1□M 210F Yrs. 81 CAROLINA Director 118-14-0693 AUG. 9, 1919 S. Usual Rasidanca of Dacedant the Marylend 10a. Stata 10d. Insida City Limits 10b. County 10c. City. Town or Location "natural", or items 23s or 28s-1 show odical Examiner must be notified at 1X Yas 2 No Director D.C. NONE WASHINGTON 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? with 1439 CHANNING ST. N.E. 20018 U.S.A. Funeral should be filed within 72 hours after deeth and Mental Hyglene.

marked other than "natural; or itema 23 immatic event, the Modical Example." mail 12. Was Decedant Evar In U.S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 M Yas 2 □ No If Yas, Giva Yaar or Datas: WWII 1 □ Nevar Marriad 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: þ 3 ☐ Widowad 4 👿 Divorced BLACK Completed 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) Collaga (1-4or 5+) Elementery/Secondary (0-12) 2 NURSE NURSING permit. Pages 1 end 2 should be file Department of Health and Mental Hys important: If item 27 is marked othe any injury or other traumatic event, price. 18. Mothar's Nama (First, Middla, Maldan Surnama) 17. Fathar's Nama (First, Middla, Last) Be JAMES MCKINNEY MATOKA McGRIFF 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) SLOANE/DAUGHTER AVE 12224 GALESVILLE DR., GAITHERSBURG, MD. 20878 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 Donation 5 Othar (Specify) 10/9/00 CHAMBERS CREMATORY RIVERDALE, MD. 21. Signature of Funeral S 22. Nama and Addrass of Facility MOOO91 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset end Deeth **Physician** Immediata Causa (Final disaesa or condition rasulting in deeth) /Medical METOSTATIC CARCINOWA Examiner Due to (or es a consaquanca of): Examiner physician end s the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Ceuse (Disease or injury thet initieted avents rasulting in daath) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequence of): ettending pl signed by the e Pert II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were eutopsy findings available prior to 24a. Wes an autopsy performad? Completed completion of causa of death? hes e 2 is certificate hes 2 BNO 2 106 1 Yes 1 Yas al or Attending Physician: T s atter death. Il Director: After this certifical ed in by the funeral director, p 25. Was case referred to medical Be 26. Placa of Death (Check only ona) xaminer? 1 ≥ Yes 2 □ No Othar: 4 Nursing Home 5 Steeldange 6 Doubler (Specing) Home 2 1 Inpatlant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 5 Panding Matural 1 ☐ Yas 2 ☐ No Investigation 2 Accidant 3 Suicida 6 Could not be determined Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 ☐ Homicide To the Hospital or within 24 hours att To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and mannar as stated.

Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. edical 29a. Cartifiar 29d. Data signed (Month, Day, Year) 29b. Sign ature and title of certifier 29c. Licansa number (DMG) N.D. P15236 October 1 2000

State Registrar

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31. Data filad (Month, Day, Yaar) OCT 0 3 2000

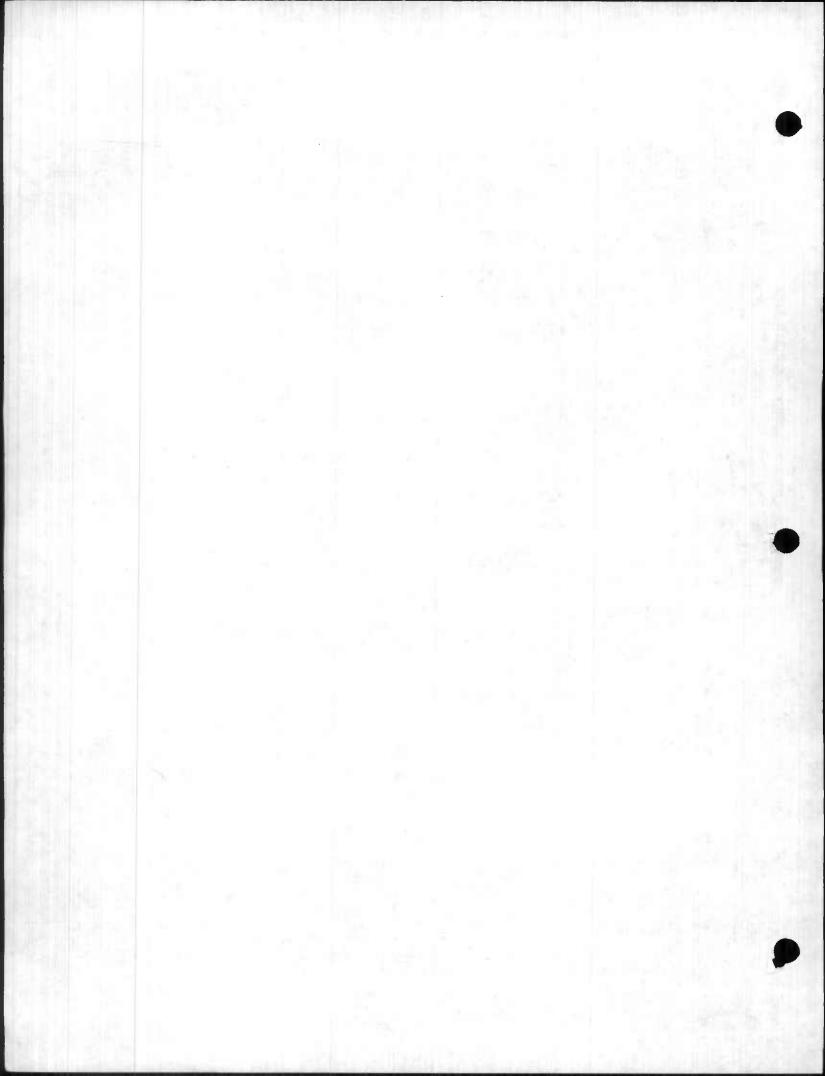
30. Nama and address of parson who complated cause of deeth (Itam 23a) (Type, Print) 25 POCKLING PIKE, POCKLING, MO LOGS) 32. Registrar's Signatura

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State of Maryland / Department of Health and Mental Hygiene 0 32742

Certificate of Death

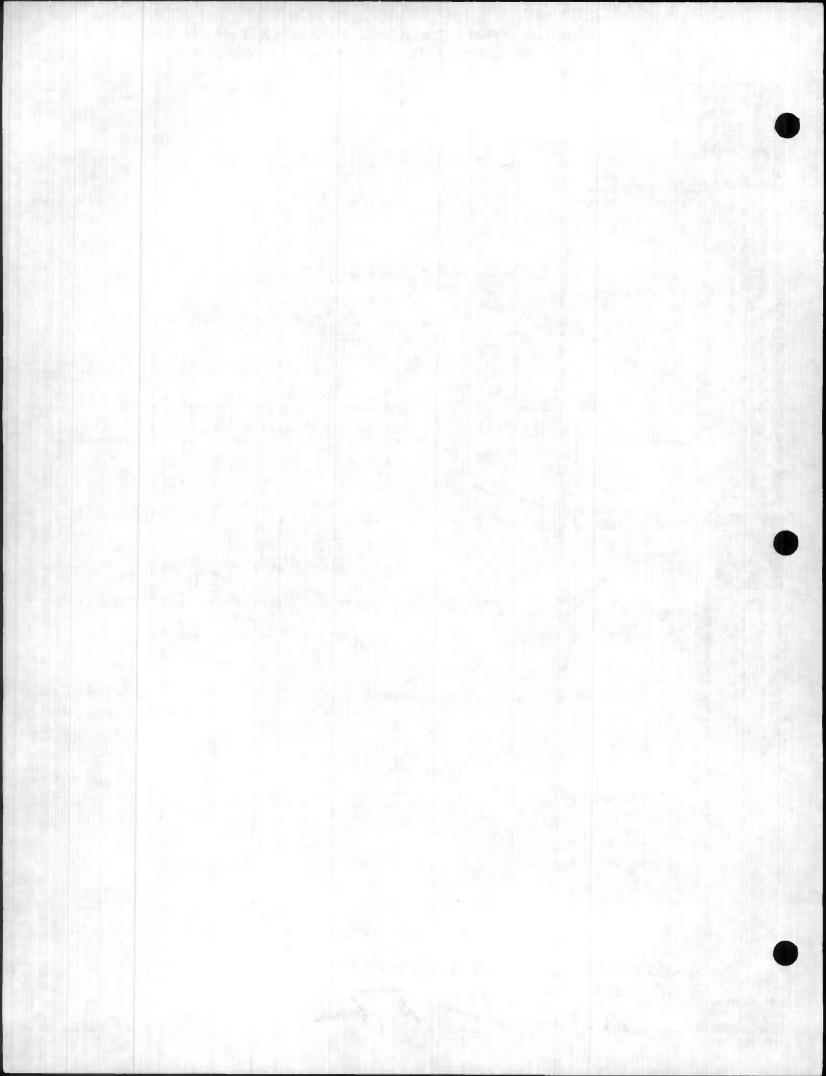
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10	/Medic	al .	Edila	J. A	nderson	1							4, 200	JU	1:15pm
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	Funeral				1□M 2対F		81 Y	Months			Min.	8. Dete of Birth (Month, Day June 22	Year)	Cour	ntrv)
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	€ 8	Director		sell Ave	#200			101. 2		20877			United		•
	after death with the Merylan or items 23s or 28s-f show most must be notified at		401 Kus	sell Ave	11309				4	.0077			United	beat	.05
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m	that the deeth led by the atter deteched for o	Physicia										1			4
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S	f or Attendil after death. Director: A d in by the fu	2	3 ☐ Suicide	6 Could not b	00 Die	on of Injune	At home fer	n, street, facto	nu offic			28f Location /5	Street and Num	her or Rur	rel Route Number,
≥	or Att	듣	4 Homicide	determined		Iding, etc. (Sp		II, Street, lact	ny, onic			City or Tou		DO1 01 1101	01710010710111007
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	To the Hospital or within 24 hours after To the Funeral Director completely filled in	edical	(Gheck only one)	2 Medical Exa	miner: On the	basis of exar enner steted.	mination and	or investigation	on, in my	opinion, de	eth occur	rred at the time,	date and place	, and due t	to the cause(s)
	within 2 To the comple	M	29b. Signefure end t	is of certifier	1			2	9c Lice	nse number			29d. Date sign	ed (Month	Dev. Year)
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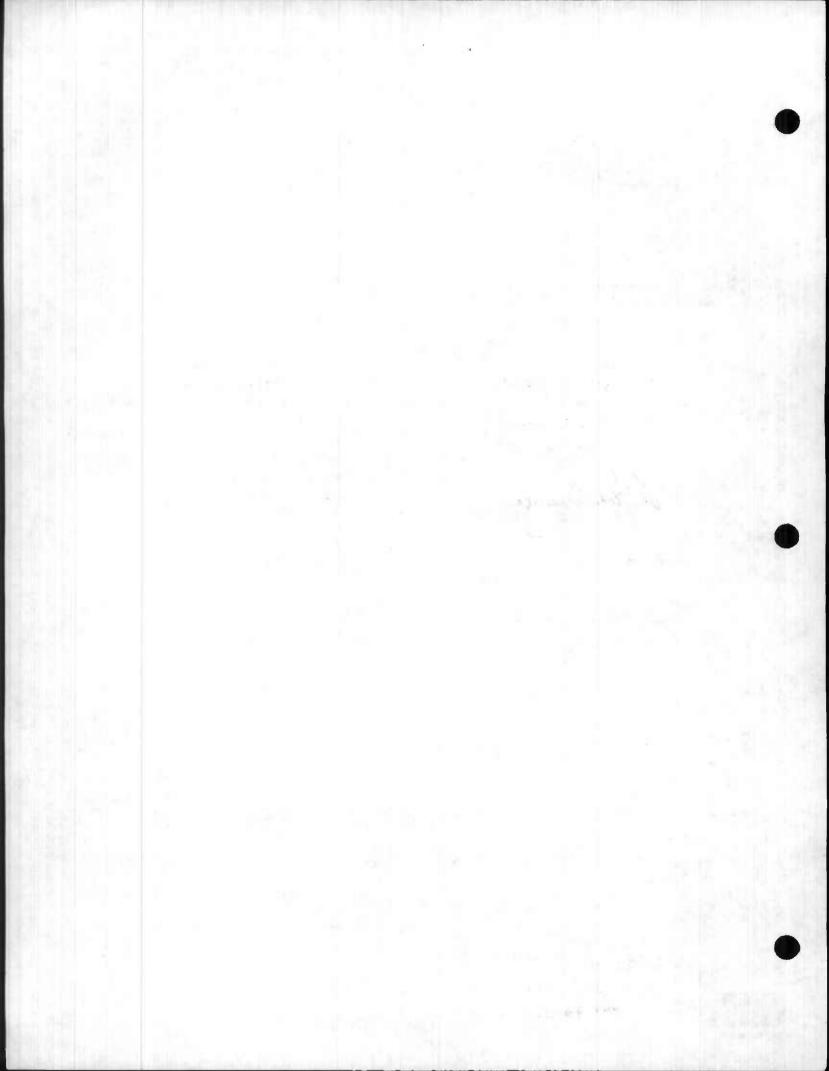
amend item	23a	27 per me G789 11/13/0	) yf		Cert	ificate of				eg. No.		32143
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/Med		LAURA LYNN ARNOLD							Ocotbe	12, 2	000	7:05 A.M.
Exami		4a Facility Nama (If not institution, give	street and number	)			4b. City, To	wn, or Lo	ocation of Death	4c. County	of Death	
19		2062 Stratton Cou	ırt				Bel	Air		Har	ford	
Funera		5. Social Security Number 6. Sa		ge (In yrs. last b	irthday)	If Under 1 Yaar	If Under	24 Hrs.	8. Data of Birth (Month, Dey			piace (State or Foreign
Director		220-82-9800	□M 20XF 3	8	Yrs.	Months Days	Hours	Min.	Nov. 9	, 1961	Mar	yland
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6 2 2	ire	10e. Street and Number				10f. Zip Coda			1	Og. Citizen of \	What Cour	ntry?
13 m		2062 Stratton Cou	rt			21015				U.S.A.		
Tre State	100	11. Marital Status	12. Was Decedan	t Evar in U,S.	13. W	as Decedant of I Yas, specify Cub	Hispanic Ori	igin? (Sp	ecify Yas or No-	14. Rac	e - Amaric	an Indian,
Maryland 21215-0020 d 2 should be filled within 72 hours after in and Mental Hygiene. 7 is marked other than "satural", or the traumette event, the Medical Examines	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 ☐ Yas 2 ☑ If Yas, Giva Yaar or Datas:	7 No		Yas, specify Cub  ☐ Yes 2 No	Specify:		Rican, etc.)	Specify	k, Whita, Wh	atc. nite
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N Page 1	2	Frank B. Oechsler					Sylv	via l	Jlrich			
and and		19a. tnformant's Neme/Ralationship (T)	rpe, Print)	19	b. Mailing	Address (Street	t end Numb	er or Run	al Routa Number	r, City or Town,	Stata, Zip	Code)
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e - F # #		20a. Mathod of Disposition	(11000 alla)			ition (Nama of atory or other pla				20c. Location -		own, State
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		23a. Part1. Enter tha disaasa, or composhock, or haart failura. List only o	na ceusa on aach	line.	not anta	r tha moda of dyl	ng, such as	Carolac	or raspiratory arr	ast,		Approximata Interval Batween
Physician												Onset and Death
/Medical		tmmediete Cause (Finel disaasa or condition	LIVDEDTENIC	TYTE ATTUED	OCCT E	DOTTC CADI	DTOVACO	TIT AD	DICEACE			
Examiner	ы	rasulting in death)	HYPERTENS	- 1			DIOVASC	ULAR	DISEASE			
	ē			Dua to (or es a	consequ	ence of):					1	
Si Si	Examiner		b. ————			100 21	-				i	
. Box 68760, death certificate be executed e attending physician and of or use as the burial-transit	Ka	Sequantially list conditions,		Dua to (or as a	consequ	ance of):					1	
\$8760, cate be execu- physician and the burial-trai		Sequantially list conditions, if any, laading to immadiate ceuse. Entar Underlying Ceusa (Diseese or injury									1	
58760, icata be ever physician s the buria	edical	that mitiated evants	c	Due to (or as a	consequ	ence of):						
fice for		rasulting in death) Last										
ding se s	3		d									
Box 6	ᇤ										1	
the de	Physician/M	Part II. Other significant conditions con	ntributing to death	but not rasulting	in tha un	darlying causa gi	van in Part	1.	23b. Dld to	obacco use co	ntribute t	o the cause of death?
. T Yes	Š								10Y	es 2 No	3□ Pro	bebly 4 Unknown
	by F								100	4		
requires									24a. Was a	n autopsy	24b. W	are autopsy findings
COTO v requir been s should	ete								parfor	med?	av	railable prior to emplation of ceusa
2 8 8	Completed	The state of the s	Ball Zell								of	deeth?
The in	0								1000	as 2 No	17	Syas 2 No
tal	0	25. Was case referred to medical					26 Dino	e of Deat	h (Check only or	nel		
of Vital I Physician: Th this certificate ral director, pag	OB	axaminar?	lospital:			_ 0	her:					
Phys ratio	-	TAS ZUNO	1 L Inpat	-		3LI DOM	⇒L N		ma 5 Rasid	_^		at scene
	Certification:	27. Mennar of Death  1 Netural 5 Pending	28a. Deta of Inj (Month, D	ey Year) 28b.	Time of Injury	28c. Inju	ry at		28d. Dascribe h	ow injury occur	red	
Division for Attanding after death. Director: After d in by the fune	atte	2 ☐ Accident invastigation				M 1	Yes 2	No				
Division or Attanding after death. Director: Afte	130	3 Suicida 6 Could not be datamined	28a. Plece of Ir	njury - At home, f	arm, stre	et, factory, offica			28f. Location (S	treet and Numl	per or Run	al Routa Number,
Die Ber	7	4 Homicida	building, a	itc. (Specify)					City or Tow	n, Stete)		
ral led												
t ho	edical	29a. Cartifier 1 Certifying Phy (Check only 2 Medicat Exami										
in 24	8	one) X	and mannar s	tated.		totigation, iiv my	op, au		od at tha tima; t	and anno pracoc,		0 114 04504(0)
Division  To the Hospital or Attendit within 24 hours after death To the Funeral Director: A completely filled in by the fi	2	29b. Signature and title of certifiar				29c. Lican	sa numbar		2	9d. Data signe	d (Month,	Day, Year)
2350		11/10	1R	1			O.C.1	M.F.	0	ctober	13	2000
		Minoder M.	14 17	Sus							10,	2000
		30. Name and address of person who co	omplated ceusa	eath (Itam 23a)				D-3			3 00	201
		THEN NORE, M. King.			111	Penn St	reet,	Ball!	cimore,	Marylar	na 21	201
St	ate	31. Data filed (Month, Day, Year)		trar's Signatura	19	do						
St Regist	_	31. Data filed (Month, Day, Year)  OCT 1 7 20		trar's Signatura	19	Span	4					



State of Maryland / Department of Health and Mental Hygiene

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						Certifica	ate of	Death		Re	g. No.	0	061.	1 1
		1. Decedent's Name	(First, Middla, La	st)						2. Dete of Deat	h	Van	3. Time of	Death
	Physiciar /Medica	ERNEST	CARRO	DLL BLA	NKENSH	IP				Month 10	1 2	000	9:30	AM C
	Examine	4e Facility Name (If	not institution, giv	re street and numb	per)			4b. City, To	wn, or Lo	cation of Death	4c. County	of Deeth		
		74 Oce	an Park	way					an P	ines	Wor	cest	er	
	Funeral Director	5. Social Security Nu 218-36-	2793	Sex 7. 1 ☑ M 2 □ F	Aga (In yrs. last bi	Yrs. If Un Month	der 1 Yaar ns Deys		24 Hrs. Min.	8. Data of Birth (Month, Day, 9 / 10 / 1	Year) 938	9. Birth	placa (Steta o	r Foraign
	Pud *	Usual Residence of I	Decedent 10b. County		10c. City, Tow	n or Location							10d. Inside Cit	ty Limits
	vith the Meryla t or 28a-f sho be notified		Worce	ester		an Pine						1 □ Yas 2 No		
	23a or 2	10e. Street and Num	cean Pa	rkway			Zip Coda 218	• •			og. Citizen of V	Α		
21215-0020	72 hours effer death with the Meryland natural; or thems 23a or 28a-f show area Examinat must be notified at the formand Director	3 □ Widowad 4		12. Was Deceded Armed Force 1 X Yas 2 If Yas, Giva Yaar or Dete	es? □ No		cedent of lipecify Cub			ecity Yas or No- Rican, atc.)	Blad	14. Reca - Amarican Indian, Black, Whita, atc. Specify: White		
5-0	ed within 72 hours ygiene. or than "natural", f, me Medeel Ex	(Specif	15. Decedant's Edy only highest gra	ducation ade complated)	16a	Decedant's U	sual Occu work dona	petion during mos	st of worki	na	16b. Kind of B	usiness/In	ndustry	
21	within ene.	Elementary/Secon		Collega (1-4	or 5+)	lifa. DO NO	Tusa ratire	ed)						
2				2		Product	ion (	7			Defen			
Maryland	2 = 2 2	18. Mofha							tta Emr		ne)	25		
lan	end end end	19a. Informent's Ner	ne/Ralationship (	Type, Print)	198	b. Meiling Addr	ess (Stree	t and Numb	er or Rura	al Routa Number,	City or Town.	State, Zij	p Coda)	
-	f Heelth frem 27 other tr	Maretta	Hoffman	n/Daught				t Dr.	Ber	lin, MD	21811			
Baltimore	S to T			Ramoval from St	ata camata	of Disposition (f ary, cramatory of Henlop	or othar pla		ory	Data 10/2/00	Franki			
Balti	permit. Pege Department: Important: if any Injury on pnca.	21. Signature of Fun	al Service Licer	1800				ass of Fecili	Bu	rbage F			ne	
	_===	23a. Part1. Enter the shock, or heart	disaasa, or com	plication that cau	used tha daath. Do								Approximate Intervel Bet	a ween
	Physician			0								1	Onsat and E	
	/Medical Examiner	Immediata Cause (F disaasa or condition rasulting in death)		. Ling	Concer Dua to (or as a			astas	ist	o Brain	+Live	2	3/38/	00
	P E S		8	0	Dou 10 (01 43 4	oonsoquunoz (	υ·· γ.							
,	executed in end itel-transit	Sequentially list conditions if any, leeding to impossible cause. Enter Under	ditions, nedieta	0.	Dua to (or as a	consequanca	of):		110		1			
68760,	certificate be executed nding physician end use as the burial-transit	cause. Enter Underl Cause (Diseasa or in that initiated evants resulting in daath) La		C	Dua to (or as a	consequenca o	of):		-					- 3
Box (	ettending ple for use as t			d										
m.	death e etter ed for u	Part If. Other eignific	ant conditions o	ontributing to deat	h but not resulting	in the undertyin	n cause n	iven in Part	f.	23b. Did to	bacco use co	ntribute 1	to the cause o	of death?
P.0	ed by the detach	COPI	>							194	s 2□ No	3 Pro	obably 4	Unknown
Records,	been signe should be d	Corona	my Ar	hery K	Disease					24e. Wes e		a	Vara autopsy f veilabla prior to ompletion of c	0
I Rec	has be 2	Hupton	o Jensie	m						1 □ Ye	s 200 No		fdeath? □Yas 2🗗	No
Vital	s certificate director, pag	25. Was casa rafarre	d to medical						a of Death	n (Check only on	a)			
of	2 00	1 Yas 2 N	6	Hospitaf:		utpatient 3□	DOA		ursing Ho	ma 5 Pasida	nce 6 Oth	ner (Speci	ify)	
ion	Attending Phor deeth.  sclor: After the by the funeral iffication:	27. Manner of Death  1 Different  2 Accident	5 Panding investigation	28a. Data of (Month,	Injury Day Year) 28b.	Tima of Injury M	28c. Inju	ury et ork? ]Yas 2 □		28d. Dascribe ho	w injury occur	rred		
Division	tal or attending P is after deeth.  Si Director: After ted in by the funer	3 ☐ Suicida 4 ☐ Homicide	6 Could not b datarmined	28a. Place of	Injury - At homa, fi , etc. (Specify)	arm, straat, fac	tory, office			28f. Location (St City or Town		ber or Rui	ral Routa Num	ber,
	Hospi 24 hou Funer tely fill				est of my knowledg is of axamination ar r stated.									)
	within 2 To the comple	29b. Signature and ti	tle of certifier				29c. Lican	sa number		2	9d. Data signe	ed (Month,	, Day, Year)	
	- > - 0	1	att	1.0	000		#10	056	181		1010	10		
		30. Nama and address	ss of person who	completed causa	of death (Item 23a)		110	1	104		1010	1.00	1	
		Scott	Sulm Day Year	an D	O. ]\\]	on R	ace	rack	R	d Ber	lin	ma	316	31)
	State Registrar	31. Data med (MONII)	Albaman da	2000	Appropriate a	B	Loan	Kal						



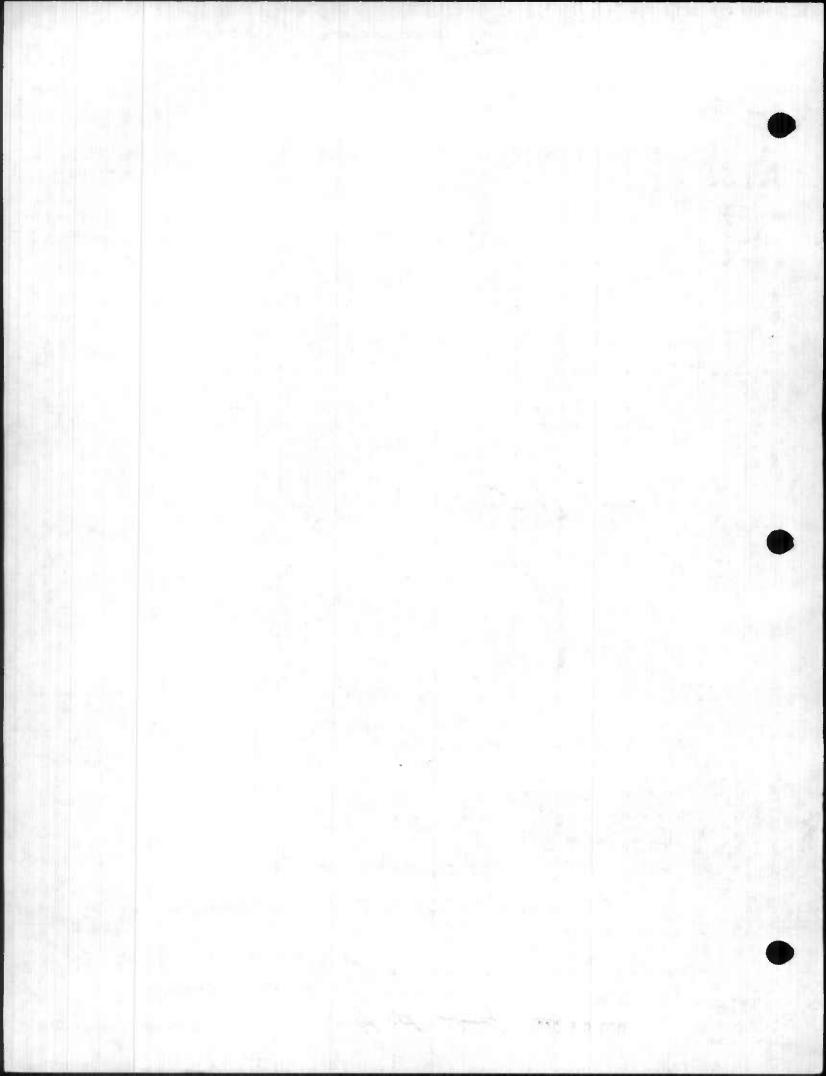
State of Maryland / Department of Health and Mental Hygiene

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_	Decedent's Name (First, Middle, Last)  2. Date of Death Month									Ven	3. Time of Death
sician	JONIBEL	TRELE	ASE E	BLAIR				Sept.	30 20	Year 00	0016
edical miner	la Facility Name (f	f not institution, gi	re street end nu	mber)			4b. City, Town, or L	-			
	Memoria]	Hospit	al Ea	ston			Easton		Talb	ot	
	i. Social Security N	umber 6.5	Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da		9. Birthol	ace (State or Foreign
	538-14-07	716	I□M 200 F	90	Yrs.	Months Days	Hours Min.	JULY 1	4, 1910	MISS	OURI
-	Jsuat Residence of IOa. State	Decedent 10b. County		10c. City,	Town or Loc	ation				10	0d. Inside City Limits
0	MD	TALE	ОТ	F	ASTON						1 <b>X</b> Yes 2 □ No
Director	IOs. Street and Nur					10f. Zip Code			10g. Citizen of \	What Count	try?
	501 DIIT	CHMAN'S	I.ANE				601	n në	U.S.A		
Funeral	11. Marital Status	· · · · · · · · · · · · · · · · · · ·	12. Was Dec	edent Ever in U,S	. 13. V	1		ecify Yes or No		e - America	
by Fur	1 Never Marri	ed 2 Married	Armed For 1 Yes If Yes, Gir Year or D	21 No		1 Yes 2√2 No Specify: Specify:				ck, White, e	
B	10	15. Decedent's E	ducation		16a. Deced	ent's Usual Occup	pation		16b. Kind of B		
ple	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)										
0		12			OCIAL	WOR	KER		STATE	GOVERI	NMENT
Be Completed	17. Father's Name						18. Mother's Nam			16)	
2	FRANK TRELEASE SADIE MAI CORNELIUS									The state of the s	
	19a. Informant's Na						and Number or Ru				
-	DONALD D. BLAIR, SR./SON 531 SOUTH WASHINGTON STREET, EASTON, ME										
2	Cemetery, crematory or other place)									- City or Town, State	
	4 Donation 5 Other (Specify)										מוא
	21. Signature of Funeral Service Licensed  22. Name and Address of Facility  FELLOWS, HELFENBEIN, & NEWNAM FUNERAL 200 S. HARRISON STREET, EASTON, MD 216										HOME,
rsician	23a. Part1. Enter ti	he disease, or con	plications that	caused the death.						210	Approximate Interval Between
	23a. Part 1. (Enter the disease, or confplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Onset and Death
	Immediate Cause (	Final		Uro	sep	515				3	3days
	disease or condition resulting in death)		a	Due to (or	as a consequ	uence of):					1
iner			b								
Examiner	Sequentially list co	nditions,	U.	Due to (or	as a consequ	uence of):				1	
	Sequentially list configuration in the sequential sequence in the sequence of	orlying injury	C								
0	that initiated events resulting in death) i		0.	Due to (or a	as a consequ	ience of):		9			
		L	d							1	
Physician/M									200	1	
ysic	Part II. Other signif				ting in the un	derlying cause gi	ven in Part f.	23b. Dld	tobacco uss co		the causs of death?
Ph	my	ocarda	infa.	rction				10	Yss 2□ No	3) Prot	bably 4 Unknow
d by	1	ocarda Imonos	()	/				240 1410	an autopsy	24b Wa	ere autopsy findings
etec	pu	monon	y fil	prosis					an autopsy omed?	ava	ailable prior to mpletion of cause
Be Completed			1							of c	death?
8								10	1000	10	Yes 2□ No
Be	25. Was case reference examiner?		Hospital: >			_ 0	26. Place of Dea				
2 -	1 ☐ Yes 2 🛣 27. Manner of Deat		1,00	-	R/Outpatient	3L DOA	4 LI Nuising n		how injury occur		у)
lon	1 Natural	5 Pending		of Injury oth, Day Year)	Injury	28c. Inju Wo	ryat urk? ]Yes 2∐No	Zou. Describe	now injury occur	180	
ical	2 ☐ Accident 3 ☐ Suicide	investigation	00 - 01	e of Injury - At hon	ne form etc			28f. Location	Street and Num	her or Ruse	I Route Number,
erti	4 Homicide	determined	288. PIEC	ing, etc. (Specity)	ie, ieliii, Sife	er, ractory, onice		City or To	wn, State)	or or mura	
edical Certification:	29a. Certifier (Check only one)	Certifying Pl	niner: On the b	e best of my know easts of examination	ledge, death on and/or inv	occurred at the ti	me, date and placa opinion, death occu	, and due to the rred at the time,	cause(s) and m date and place,	anner as st and due to	tated. the cause(s)
	29b. Signature and	title of cartifier	and mar	iner stated.		29c. Licen	se number		29d. Date signe	d (Month	Day, Year)
	1	1	Horns	Laura	Ten		055484	,			2000
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3	30. Name and addf						, EASTON,	NO 016	0.1		

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Registrar



State of Maryland / Department of Health and Me

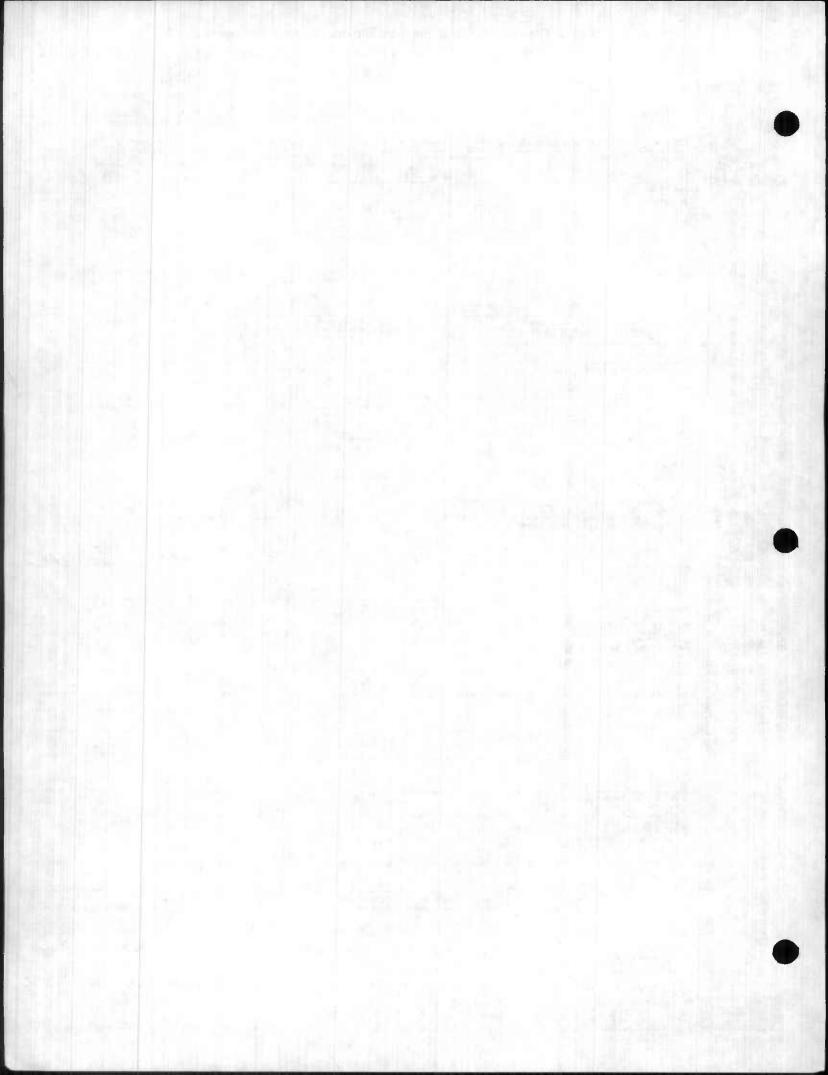
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BENSON			Certificate of	Death	Reg	. No.	OLITO		
	1. Decedent's Name (First, Middle, Last)				2. Date of Death				
Physician	PAMELA JEAN BENSON			Month OCTOBER	04. 2000	22:39 PM			
/Medical Examiner	4a Facility Nama (If not institution, give str	eet end number)		4b. City, Town, or Lo		4c. County of Dea			
LABITITIET	PRINCE GEORGES HOS	SPITAL CENTER		CHEVERLY	EW .	PRINCE	GEORGES		
Funeral	5. Social Security Number 6. Sax	7. Age (In yrs. last bit	thday) If Undar 1 Year Months Days	If Under 24 Hrs.	8. Data of Birth (Month, Day, You JULY 22,	9. Bir	thplace (Steta or Foreign ountry)		
Director	228-90-7991	1957	MD						
	Usual Residence of Decedent								
M M	10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits		
the Marylan radified at rector	MD CALVERT	DUNK	IRK				1 ☐ Yas 2 🕅 No		
or 28s-fa be notified	10e. Street and Number	914 - 10101	10f. Zip Code		109	. Citizen of What C	ountry?		
	9912 MCINTOSH DRIV	F	2075	/1		USA			
free death in the same 23 sine craust	11. Marital Status 12	. Was Decedent Ever in U,S.	13. Was Decedent of I	Hispanic Origin? (Sp	ecity Yas or No-	14. Race - Am			
3 22 5	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No		an, Mexican, Puarto	Hican, etc.)	Black, Whi			
bours after unal; or he at Examine	3 ☐ Widowed 4 🛣 Divorced	if Yes, Give Year or Dates:	1 ☐ Yes 2X No	Specify:		Specify: WI	ILTE		
72 ho	15. Decedent's Educa	tion 16a	. Decedant's Usual Occu	pation	. 16	b. Kind of Business	/Industry		
21215-U ed within 72 ho ygiene. Net then "natur A. the Medical Completed	(Specify only highest grede of Elamentary/Secondary (0-12)	Completed) College (1-4or 5+)	Decedant's Usual Occu (Give kind of work done life. DO NOT use retire	during most or work id)	ing				
the the	11		FOOD SE	ERVICE					
D EITES 0				18. Mother's Nam	e (First, Middle, Ma	iden Sumame)			
Mad of the second of the secon		JR.		PHYLLI	S MARIE C	OBER			
Show of M	19a. Informent's Neme/Reletionship (Type		. Mailing Address (Stree				Zip Code)		
and 2 sallh a 127 is er trau	DAVID G. BENSON, I	II 9	912 MCINTOS	H DRIVE,	DUNKIRK.	MD 20754			
D - E - E	20a. Method of Disposition	20b. Place of	f Disposition (Neme of			c. Location - City or	Town, State		
emit. Pages 1. Separiment of He mportant: If Hen my injury or oth	MXBurial 2 Cremation 3 Rer	noval from State	ry, cremetory or other ple EW CHURCH C		0-8-2000	COPDOMA	MD		
The party of the p	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Sarvice Licensea	PALKVI	0-8-2040	CORDOVA,	MU				
D D D D D D D D D D D D D D D D D D D	21. Signature of Furieral Salvice Licensea	EASTON,	MD 21601						
	FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, H								
	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one	tions that caused the death. Do cause on each line.	not enter the mode of dyi	ing, such as cardiac	or respiratory arrest	1,	Approximate Intarval Between Onset and Death		
/Medical Examiner us and ward ward ward ward ward ward ward war	Immediate Cause (Final disease or condition resulting in death)  a.  Sequentially list conditions, if any leading to immediate		consequence of):						
entificate be ing physicia as the bur	Couse (Disease or injury that initiated events:  that initiated events:  c.  Due to (or as a consequenca of):  rasulting in daath) Last								
at the death of the death of the attend for us	Part II. Other significant conditions contri	buting to death but not resulting I	n the underlying cause gi	ven in Part I.	23b. Did toba	acco use contribut	s to the cause of death?		
d by the letached	Marie Control (1979)		1 Yes 2 No 3 Probably 4 Unkn						
							• •		
					24a. Was an a		Ware autopsy findings available prior to		
law requires been as been 2 should					pononna		completion of cause of death?		
The law requir sate has been s page 2 should Completed					1 Yas	2 🗆 No	1 Yes 2□ No		
Iclan: The certificate rector, pag	25. Was case referred to medical			Of Place of Deep		20.10	14(100 2010		
Physician: T this certificat ral director, pr	examiner?	spital:	OI	her:	th (Check only one)	0 DOW (C-	2014.1		
Phys rai di	1 Yes 2 No  27. Menner of Death	1 ☐ Inpatient 2 ☐XER/O	utpatient 3L DOA	4   Nursing no	ome 5 Resident	-	ecity)		
be or Attending P is after deeth.  In Director: After the funer of in by the funer Certification:	1 Netural 5 Pending	(Month, Dey Year)	Injury Wo	Yes 20 No	redistri	- sta	ca bushe		
Lor Attending after deeth. Director: After d in by the fune	2 Accident investigation   1   Yes 2   No   No   No   Yes 2   No   No   No   No   No   No   No								
Direct in b	4 Homicide determined	n=1-13	City or Town,	Stere) Nort	= 260 nex				
plts ours ours	20a Cartifice 1 Cartifying Physic	Jan. To the heat of my knowledge	does he control at the	ime date and place	and due to the cau	wings M	and and		
To the Hospital or Atte within 24 hours after de to the Funeral Direct completely filled in by it Medical Certific	29e. Certifier (Check only one)  1 Certifying Physic 2 Medical Examine	ian: To the best of my knowledger: On the basis of examination are	e, death occurred at the tond/or investigation, in my	opinion, death occur	red at the time, date	and place, and du	is stated. le to the ceuse(s)		
within 2 To the comple	29b. Signature and title of certifiar	and manner stated.	29c. Licen	se number	290	I. Date signed (Mor	oth Day Year)		
<b>L</b> 1 5 0	255. Signature and little of certifial	V	001			CTOBER 0			
	Theoder M.	Ferg ray	HALL BUILDING						
	30. Name and address of person who com	pleted cause of death (Item 23a)	(Type, Print)						
	THOODER M. K.	ig :	111 Penn Str	reet, Balt	imore, Ma	aryland 2	1201		
State	31. Dale filled (Month, Dey, Year)	32. Registrar's Signature	4 1						
Registrar	OCT 0 6 200	10 Depense	D. Apac	KN					

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 32747

				C	ertifica	te of	Death	Va. Cont.	Reg. No.				
		1. Decedent's Name (First, Middle, Las	1)		-			2. Deta of Month	Death Dey	3. Time of Deeth			
e.	Physician /Madical	CHARLES WILLIAM	M BAECHLER					SEPT.					
	/Medical Examiner	4a Facility Neme (If not institution, giva	street and number)	and the second		4	b. City, Town,	or Location of De	ath 4c. County	of Death			
	Examine.	SHADY GROVE	ADVENIETO	m HOCD	TMAT	- 14	DOCK	7777777	MONT	TGOMERY			
-	Curaval	5. Social Security Number 6. Se		In yrs. last birthde	(V) If Unde	er 1 Yaer	If Under 24	WILLE Hrs. 8. Date of					
	Funeral Director		MM 2□F	80 Yrs.	Months	Deys	Hours M	Hrs. 8. Date of (Month, OCT.	Dey, Year) 3, 1919	9. Birthplace (State or Foreign Country) PENNSYLVANIA			
	Director	Usuel Residence of Decedent						001.	3, 1919	FENNSILVANIA			
	and and	10a. State 10b. County	1	Oc. City, Town or	Location					10d. Inside City Limits			
	Aery or	MARYI AND MONTCOM	ZD3Z		OOUTT	T T T?			10				
	ith the Me or 28e-f a	MARYLAND MONTGOME	LKI	1	ROCKVI				140-02	10-1-0-1-1-0			
	Dir So	Toe, Street and Number			101. 2	ip Code			10g. Citizen of V				
	23 th	14632 BAUER DRIVE	APT. #7				53-2456		UNITED S				
	72 hours efter death with the Meryland natural; or frems 23s or 28s-f show final Essenties must be notified at sted by Funeral Director	11. Marital Status	12. Wes Decedent Eve Armed Forcas?	er in U,S.	<ol><li>Was December 11 Yes, sp</li></ol>	edent of Hecity Cube	ispanic Orlgin' en, Mexican, P	? (Specify Yas or uerto Rican, etc.)	No- 14. Rac Bled	e - Amarican Indien, ck, White, etc.			
2	offe of F		1 X Yes 2 □ No If Yes, Give		1 ☐ Yas		Specify:						
2	nal.		Year or Datas: 1 9	939-44	1 60	1.021.00	Openiy.		Зрасну	WHITE			
	ed within 72 hours ygiene. er than "natural", r, tre Medical En-	15. Decedent's Ed	ucation	16e. De	cedent's Us	uel Occup	etion during most of	working	16b. Kind of Bu	usinass/Industry			
0700-01717	within 7 in then *r	(Specify only highest grad Elementery/Secondary (0-12)	College (1-4or 5+)	life	DO NOT	use retired	duning most of	WORKING					
7	r than	Elisticity/sociality (6 12)	4		GINEER				US POSTA	AL SERVICE			
0	= 1 # P						18. Mother's	Nema (First, Mide	da, Meidan Sumem	10)			
maryland	Mental Barked of Bric even		ER. SR.				ANNA	K. LIVVE	RT				
2	2 should end Men is marke aumatic	19e. Informent's Name/Relationship (T		19h Me	ailing Addre	ss (Street			nber, City or Town,	State, Zip Code)			
E	~ 0 0 0	JEFFREY C. BAECHLE	**				LISON L			VA 23113-1422			
a)	E E E	20a. Method of Disposition						Dete		City or Town, State			
baltimore,		1 Burial 2 ACremation 3	Removal from Stata	20b. Plece of Dis cemetery, o	remetory or	other plea	(e)			Oily of Town, State			
	ury in Pa	4 Donation 5 Other (Specify	)	FT. LIN	COLN (	CREMA	TORY	09/30/0	O BRENTY	WOOD, MD			
5	Department of Important: If II eny Injury or page.	21. Signature of Funeral Service Ucens	19/	,			ss of Fecility	777 1103	T. T				
0	89 E 2 B	Medad	-					IERAL HOM		PRING, MD 20904			
		23a. Pert1. Enter the disease, or comp	lications thet caused th	e death. Do not						Approximete			
	Dharistan	shock, or heart feilure. List only of	ne cause on each line.							Intervel Between Onset and Death			
À	Physician // /Medical	Immediate Ceuse (Final	11			Pa		-0 (	1.1500				
	Examiner	disease or condition resulting in death)	a. META	STATI	_	PRO	SIA	e c	ANCER	) YEAR			
	- I		Du	ue to (or es e con:	sequence of	):							
	الم الم		b										
	certificate be executed ding physician and ise as the burial-transit	Sequentially fist conditions, if eny, leading to immediate cause. Enter Underlying	Du	ue to (or es a cons	sequence of	):				THE PROPERTY OF			
Ď.	Sian Sian Suria	cause. Enter Underlying Cause (Disease or injury											
09/90	physicies the buse of the buse	that initieted events resulting in death) Last	Du	ia to (or as a cons	aquance of	):			- 21				
	ding p												
DOX			d										
	death of ettended for us	Part II. Other significant conditions co	entributing to death but r	not resulting in the	underlying	cause giv	en In Pert I.	23b. D	Id tobacco use co	ntribute to the cause of death			
5	the sch				, and only mag	outer g			Yes 20 No	3 Probably 4 Unknow			
7	y P								_ 165 Z= 160	0_110000, 1_01mmon			
vital necords,	requires that seen signed to hould be detected by Pi							24a W	es en eutopsy	24b. Were autopsy findings			
5	been si should should								erformed?	available prior to completion of ceuse			
Ď	hes to ye 2 s								/	of deeth?			
	E # 8 8							1	Yes 22 No	1 □ Yes 2 No			
2	ystclan: The scartificate director, pag	25. Wes case referred to medical examiner?					26. Plece of	Deeth (Check on	ly one)				
>		1 ☐ Yes 2 ☑ No	Hospitel: 1 Inpatient	2 ER/Outpe	ient 3 C	OA Oth	er: 4 Nursi	ng Home 5□R	esidence 6 DOth	ner (Specify)			
5	er this neral d	27. Menner of Death	28a. Dete of tnjury (Month, Dey Y	(ear) 28b. Time	of	28c. Injur Wor	y at	28d. Descri	oe how injury occur	red			
ō	tal or Attending P rs after death. Is Director: After to led in by the funera Certification:	1 Neturat 5 Pending 2 Accident investigation	(Moran, Doy 1	bar, injui	M		Yes 2□No						
DIVISION	or Attendiate death Director: A d in by the f	3 ☐ Suicide 6 ☐ Could not be	266. Piece of injury		street, fecto	ory, office				ber or Rurel Route Number,			
5	Pire lint	4 Homicide	building, etc. (	(Specify)				City or	Town, Stete)				
		29e. Certifier 1 Certifying Phy	vsician: To the best of n	ny knowledge da	eth coourre	d at the tim	ne data cad -	lene and due to t	he causelst and me	enner as etated			
	n 24 hours n 24 hours ne Funer pletely fil	(Check only 2 Medical Exam	Iner: On the basis of ex	kaminetion end/or	investigation	n, in my o	pinion, death	occurred et the tin	ne, date end plece,	and due to the cause(s)			
	thin thin the mple	29b. Signature and title of certifier	and menner stete	u.		9c. Licens	a number		29d Data signs	ed (Month, Day, Year)			
	F 3 F 8	'/	16000-	1- 112				7					
	10	Tough M.	Hægger	cy MI	)	DZ	240		septemb	ser 28,2000			
		30. Name and eddress of person who c		th (Item 23a) (Typ	e, Print)								
		JOSEPH M. HAGG	erry MO	9707	Med	DICAL	CTR	DRIVE	ROCKUIL	Le, MO 2085			
	State	31. Dete filed (Month, Day, Year)	32. Registrer's		-	a Ka							
		CHOT 13 9 70	FIFE / Cuch	1	1261	200 100							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Deeth 1. Decedent's Nama (First, Middle, Last) Month **Physician** 30, 2000 SEPT 3:15 PM MELVIN R. BANKS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner MONTGOMERY ROCKVILLE CASEY HOUSE 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 10M 20F Months Days Hours 82 Yrs. NEW YORK 09-03-1918 Director 148-05-9923 Usuei Residence of Decedent the Maryland r 28a-f show 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo MONTGOMERY SILVER SPRING MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code e filed within 72 hours after death with al Hygiene.
other than "natural", or Nems 23s or vent, the Mancel Examiner manton. 20906 USA 15115 INTERLACHEN DRIVE #818 Funeral 14. Raca - American Indian. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Bieck, White, etc. 1 ☐ Yes 2 No If Yes, Giva Yaar or Datas: 1 Nevar Married 2 Married WHITE 1 ☐ Yas 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Coilege (1-4or 5+) AGRICULTURAL STATICIAN U.S.D.A. 4 permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy,
Important if Nem 27 is marked other
any Injury or other traumest-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be EDITH WISOTSKY ABRAHAM BANKS 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 15115 INTERLACHEN DR #818, SILVER SPRING, MD 20906 FIORENCE BANKS/WIFE 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stata 20a. Method of Disposition OCT 3, 1 ☐Burial 2 ☐ Cramation 3 ☐ Ramovai from 5 1 4 ☐ Donation / 5 ☐ Other (Specify) JUDEAN MEMORIAL GARDENS 2000 OLNEY, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility EDWARD SAGEL FUNERAL DIRECTION, INC. 23a. Part1. Enter the disease, or community that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast,

Appropriate the mode of dying, such as cardiac or respiratory arrast,

Appropriate the mode of dying and the disease of th 20852 Approximete fnterval Between Onsat and Death **Physician** Immediete Cause (Final disease or condition rasulting in deeth) /Medical a. NON-HODGKINS LYMPHOMA MONTHS Examiner Due to (or as a consequenca of) Examiner certificata be executed physician and Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequenca of): Physician/Medicai Due to (or as a consequenca of): 88 USB 23b. Dtd tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. the 3 1 Yee 2 No 3 Probably 4 Unknown signed b by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has a 2 paga 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Piace of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify)HOSPICE 10 1 Yes 2 No this 27. Menner of Death 1 Delurel 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred edical Certification:

68760 Box P.O. Records, of Vital Division

Baltimore, Maryland 21215-0020

for Attending Physician: after death. Aftar after death.

Director: Aft
d in by the fur To the Hospital or within 24 hours aff To the Funeral DI completaly filled in

12

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end pleca, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifian

1 Yes 2 No

D15046

28f. Location (Street end Number or Rural Route Number, City or Town, State)

actober 1, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000

5 Pending investigation

6 Could not be determined

2 Accident

4 Homicide

31. Dete filed (Month, Day, Year)

OCT 0 4

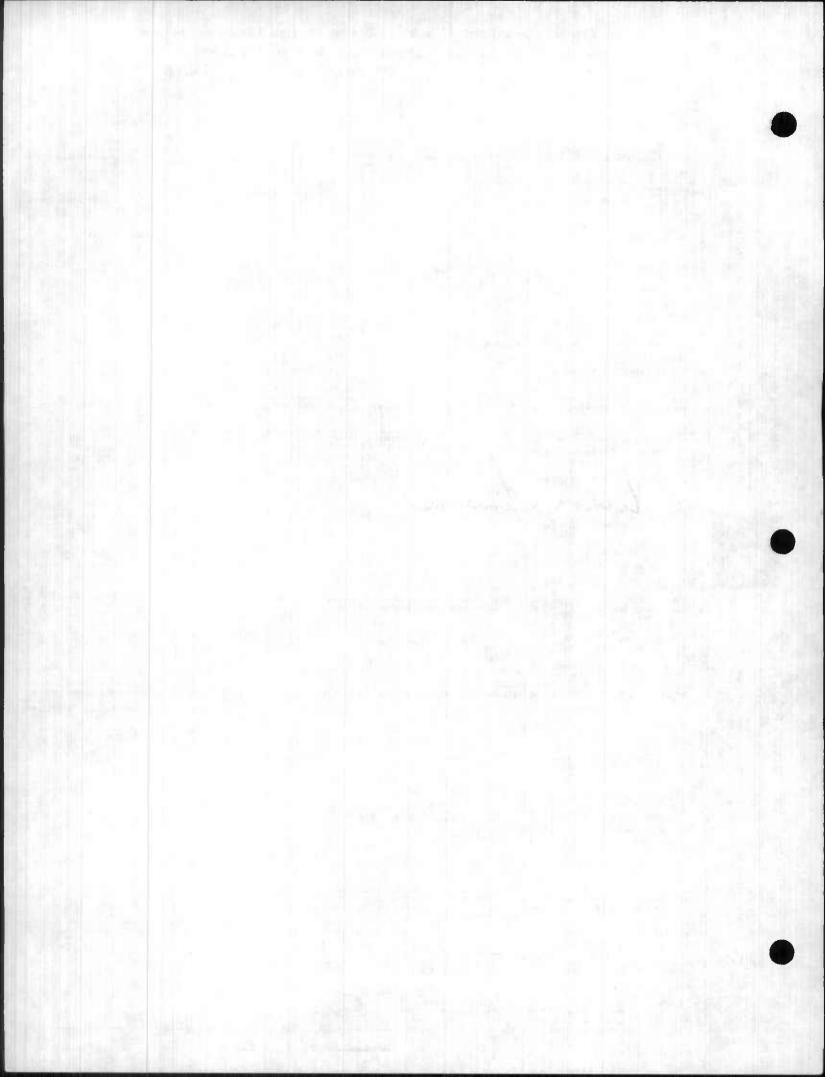
3 Suicide

6001 MUNCASTER MILL ROAD, ROCKVILLE, MARYLAND 20850 STEPHEN NEWMAN, MD

State Registrar

32. Régistrar's Signature

28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

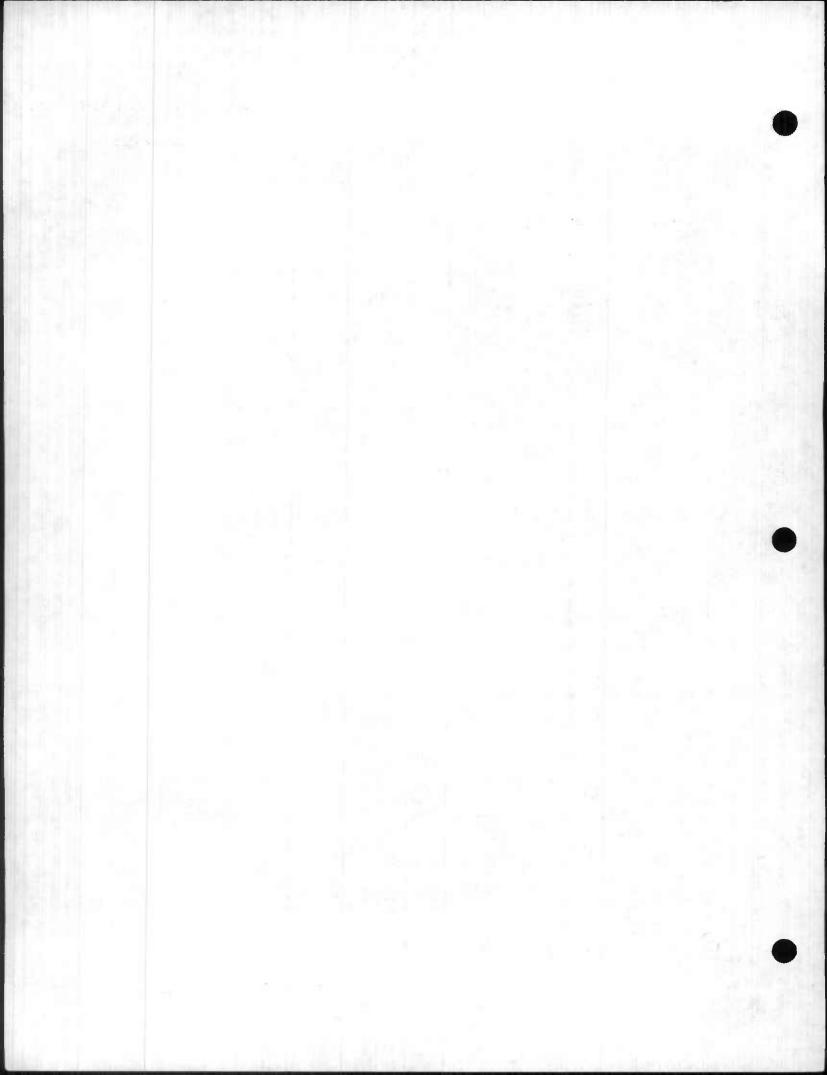


State of Maryland / Department of Health and Mental Hygiene

ene	00	3	2	7	L	(
No			Line	1		-

			Ce	ertifica	te of	Death	1		Reg. No.		Bras II	-
	1. Decedent's Name (First, Middle, Last)										3. Time	of Deeth
hysician	Lois M. Beckett							Month October	Day 1, 2	Year 2000	1:00	P.M.
Medical kaminer	Ab City Town or I						ocation of Deet	-	of Death			
ammer	Bedford Court	Nursing Home				Silv	er S	pring	Montg	omerv		
al I			yrs. last birthde		er 1 Yeer	If Under	24 Hrs.	8. Date of Bir (Month, Da	0			e or Foreign
	300-24-7700	1□ M 2\ F 91	Yrs.	Months	Days	Hours	Min.	June 4	, 1909	Kansa	lry)	
	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location										Od Inside	City Limits
ctor	Maryland Prince G		emple H									es 2 No
I Directo	10e. Street and Number 5206 Springwood	Drive			ip Code 20748	3			10g. Citizen of 1			
Funeral	11. Meritel Status	12. Wes Decedent Ever	in U.S. 13	. Wes Dec	edent of I	Hispanic Or	rigin? (Sp	ecity Yes or No	- 14. Rac	a - America	an Indian,	
Ď	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Yeer or Dates:		If Yes, sp 1 ☐ Yes	ecify Cub	Specify	in, Puerto	Rican, etc.)	Bla	ck, White, e		
eter	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dec (Giv	edent's Us	uel Occup ork done	oation during mos d)	st of work	ing	16b. Kind of B	usiness/Ind	lustry	
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Teac	_	use retire	d)			Federal	Gove	rnme	nt
Ö	17. Father's Name (First, Middle, Las					18. Moth	er's Nem	e (First, Middle	, Maiden Sumer			
o Be	Charles C. Beckett							lle War				
-	19a. Informant's Name/Reletionship	Type, Print)	19b. Ma	iling Addre	ss (Street	and Numb	per or Rur	a i Route Numb	er, City or Town,	State, Zip	Code)	
	Virginia B. Chic	nester/Niece	5206	Spri	ngwo	od Dr	ive,	Temple	Hills,	Mary	land	20748
	20a. Method of Disposition 1 ☐ Buriel 2 🂢 Cremetion 3 [	Removal from State	Ob. Place of Dis cemetery, cr MONTGOM	position (N	ame of		0	Date CTOBER	20c. Location	- City or To	wn, State	
	4 Donation 5 Other (Special Signature of Foneral Service Lice		CREMATO	RIUM	INC.			, 2000	BETHES			AND
	1/2 0%	let .	100335 R	obert ockvi	lle,	Inc. Marv	300	West M 20850-	Home/ lontgome 2805	ry Av	enue	
	23a. Part1. Enter the distance, or conscious shock, or heart failure. Lat only	plications that caused the one ceuse on each line.	death. Do not e	nter the me	ode of dyi	ng, such es	s cardiac	or respiratory a	rrest,		Approxim Interval E Onset an	Between
n al er	Immediate Cause (Final disease or condition resulting in deeth)	a Arterioso	lerotic	Card	iova	scula	r Di	sease		1	4 Yea	ars
	- Cooking in addition	Due	to (or as a cons	equence o	):					2		
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	to (or as e cons	equenca o	):	2.7	7					
ical E	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Lest	c	to (or es e cons	equenca of	):					1		
₹ 2	resulting in Gealth) Less	d								1		
Physician/	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did fobacco use contribute to the cause of death?				
hys								Yes 2 No				
by	Severe Alzheimer's Disease									_		
Completed								24e. Was	an eutopsy ormed?	ava	ere autops aliable prid mpletion o death?	sy findings or to of cause
mo								10	Yes 2 X No		Yes 2	
0	25. Was case referred to medical					26 Plea	e of Dea	th (Check only				
m	examiner?	Hospital:	2 ER/Outpati	ient 3 🗆 l	Ot Ot	hor:				ner (Snecih	v)	
	27. Manner of Deeth  1 X Netural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	-	of	28c. Inju			ome 5 ☐ Residenca 6 ☐ Other (Specify)  28d. Describe how injury occurred				
Certification:	3 Suicide 6 Could not to determined	28e. Placa of Injury - building, etc. (S)	At home, farm, soecify)	street, facto	ory, offica			28f. Location ( City or To	(Street and Num wn, State)	ber or Rura	l Route N	um <i>ber</i> ,
Medical Cert		nysician: To the best of my miner: On the basis of exa end manner steted.										e(s)
M	29b. Signeture and title of certifier	Settle II en	19-111	2	9c. Licen	se number			29d. Date signe	ed (Month,	Dey, Year	)
12	I Some	1. Rosai			D 2	24543			Octobe	r 2,	2000	
	30. Name end address of person who				. 7 1	D . 1		1 011	. C	Mari	1	1 2000
	James A. Rossi, M			ire We	orld	RonTe	evaro	511ve	spring	, Mar	yran	u 2090
State	31. Date filed (Month, Day, Year)	32. Registrar's S		1	100 00	2.5						

DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 28, 2000 Zoltan Berkovits 7:30pm 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street end number) 4c. County of Death Olney If Under 24 Hrs. Montgomery General Hospital Montgomery If Under 1 Year 5. Social Security Number Birthplace (Stete or Foreign Country) 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) 1 X M 2 □ F Months Days Hours Min Yrs. 126-74-9354 86 January 17,1914 Romania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14510 Homecrest Road #2019 20906 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Bleck, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martin Berkovits Berta Landesman 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Magda Berkovits / Wife 14510 Homecrest Road #2019, Silver Spring, MD 20906 20a. Method of Disposition 20b. Piace of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date MBuriel 2 Cremation 3 Removal from State 10/02/00 4 ☐ Donation 5 ☐ Other (Specify) Chesed Shel Emmes Washington, DC 22. Name and Address of Facility Danzansky Goldberg Memorial Chapel, Inc 21. Signature of Funeral Service Licensee 1170 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death AMYOTROPIC LATERAL SCLEROSIS Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of) Due to (or as a consequence of) Due to (or as a consequenca of):

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Directo

Funeral

by

Completed

Be

**Funeral** 

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: If Itam 27 is marked other than "natural", or froms 23a or 28a-f show any Injury or other traumatic event, the Mos call Example must be notified any Injury.

Baltimore, Maryland 21215-0020

and SE director

The law requires that the death certificate be executed

Physician:

or Attending

Hospital

0

within 2 To the I

Division of Vital Records, P.O. Box 68760,

physician a attending ( signed by the a should ! irector, page this funeral Aftar daath. n 24 hours after death.

• Funeral Director: A

oletely filled in by the fo

Examine Certification:

Physician/Medical þ Completed å 2

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes en eutopsy performed?

24b. Were autopsy findings eveilable prior to completion of cause of death?

1 Yes 2 No 1 Yes 20 No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was case referred to medical examiner? 1 Yes 2 No 27. Menner of Deeth

2 Accident

3 ☐ Sulcide

29a. Certifier

4 Homicide

5 Pending investigation

Hospital:

28a. Date of Injury (Month, Dey Year) 6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

 Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 (1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es steted.

(Check only one) 2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. 295. Signature and title of certifie

30. Name and address of person

29c. License number

29d. Date signed (Month, Dey, Year)

SEPTEMBER 29, 2000

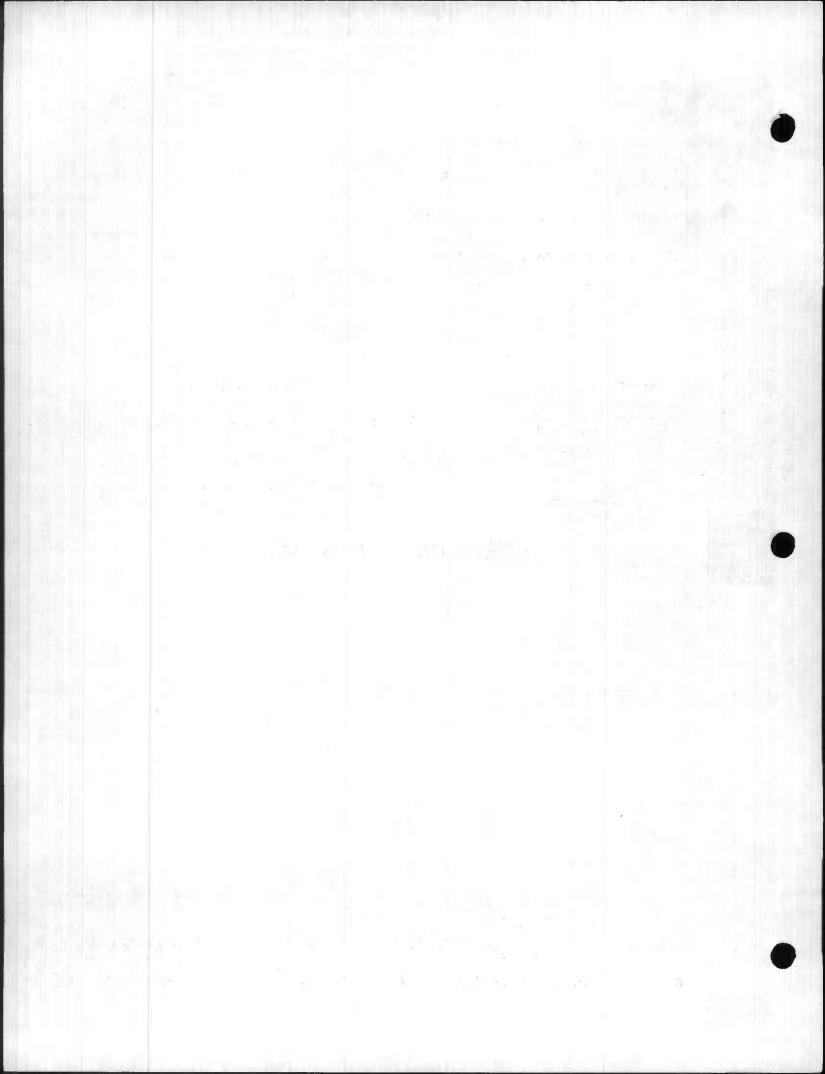
31. Date filed (Month, Dey, Year) 2000 04

32. Registrar's Signature

TONAR DR #211, S.SPRING, MD

Registrar

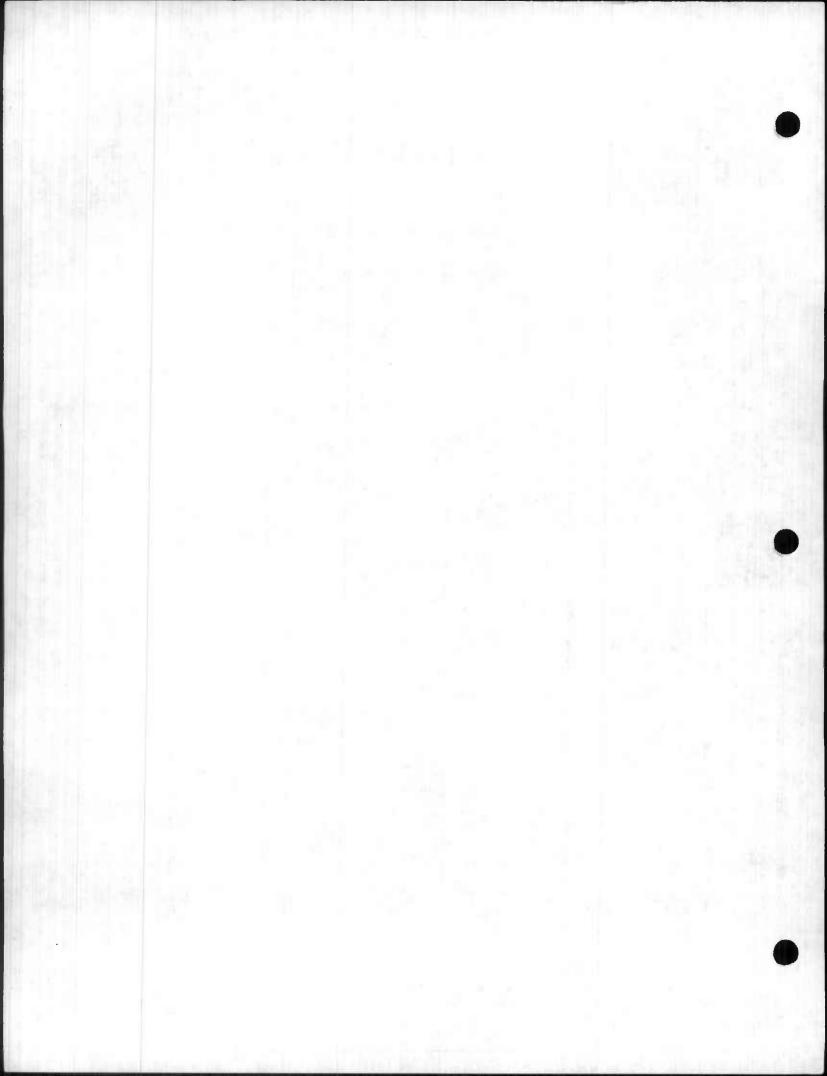
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State of Maryland / Department of Health and Mental Hygiene

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				Ce	rtifica	te of	Death			Reg. No.	0	06.10	
		Decedent's Name (First, Middle, Last)							2. Dete of D Month		Vane	3. Time of Dear	th
L.	Physician /Medical	Margaret Harmon Blake							September 29, 2000 6:46				
	Examiner	4a Facility Name (If not institution, give street end number)						wn, or Lo	of Death				
		15307 Frederick Ro	ad				Wood	dbin	e	Но	oward		
_	Funeral	Social Security Number     6. Se	77	n yrs. last birthdey	) If Unde	r 1 Year Days	If Under:	24 Hrs. Min.	8. Dete of B	rth ey, Year) y 6, 1917	9. Birthpi	lace (Stete or For	eign
	Director	113-09-0562	DM 200 F	83 Yrs.	MORITIS	Days	riours	Will I.	Februar	6, 1917	New	York	
	7 .	Usual Residence of Decedent											
	athon T	10a. Stete 10b. County		0c. City, Town or L							10	0d. Inside City Lir 1 ☐ Yes 2	
	cto diffe on	Maryland Howard		Wo	odbin	e	1915		1-0-			1 Hes 210	NO
	or 28s-f s be notified Directo	10e. Street and Number			10f. Zi	o Code				try?			
		15307 Frederick Ro	ad	may be an		217	97			United S	State	S	
	r here 23 siner must Funeral	11. Meritel Status	12. Wes Decedent Eve Armed Forces?	er in U,S. 13.	Was Dece	dent of H	lispanic Origin, Mexican	gin? (Spe	ecify Yes or N Rican, etc.)	o- 14. Race Blac	e - America k, White, e		
20	ar she brando	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:		1□ Yes	2 🗓 No	Specify:			Specify	Whi	.te	
Maryland 21215-0020		15. Decedent's Edu	ication	16a. Dece	edent's Usu	al Occup	ation			16b. Kind of Bu	usiness/Inc	lustry	
215	ed within 72 ho ygene. we than "natural, the Medical. Completed	(Specify only highest grad Elementery/Secondary (0-12)	le completed) College (1-4or 5+)	(Give	DO NOT	ork done ise retired	during most	t of work	ing				
2	Com	12	College (1-401 37)	R	ecept	ioni	st			Funera	al Ho	me	
P	ETES 0	17. Fether's Neme (First, Middle, Last)			18. Mothe	r's Name	First, Middle	e, Maiden Sumem	Θ)				
100	Mental Mental Marked of Street every To B	Joseph Harmon					Seli	na K	aufold				
any	4266	19a. Informant's Neme/Reletionship (T)	vpe, Print)	19b. Mail	ling Addres	s (Street	end Numbe	er or Ruri	al Route Num	ber, City or Town,	Stete, Zip	Code)	
	and 2 selfth a	Kathleen B. Curry/	Daughter	1530	7 Fre	deri	ck Roa	ad,	Woodbi	ne, Maryl	Land	21797	
ore.	-116	20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (Ne	me of	ce)		Date	20c. Location -	City or To	wn, State	
Baltimore,	O Tree	1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	removal from State	Montgome						Betheso	la, M	aryland	
alti	and	21. Signeture of Funeral Service Licen		2	22. Name a	nd Addre	ss of Fecilit	y Rob	ert A.	Pumphrey	Fun	eral Hom	ne/
œ	40 F 8	· Will Ex	ouer h	00672 R	ockvi	lle,	Inc.	30	0 West	Montgome 0-2805	ery A	venue,	
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	lications that caused the	e deeth. Do not er	nter the mo	de of dyir	ng, such as	cardiac (	or respiratory	errest,		Approximate Interval Between	
	Physician	Shock, of heart failure. List only of	ne cause on each line.	,							1	Onset and Deeth	1
d	/Medical	Immediate Cause (Final disease or condition	Gastro	intestin	a1 B1	eedi	ng					1 Month	
	Examiner	resulting in death)	w	e to (or as a conse			6				-	1 11011011	
-	D E		Cardio	respirat	ory A	rres	t						
	executed in and rial-transit	Sequentially list conditions,	D	e lo (or as a conse									
0	ian a unial-	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury									1		
68760,	icate be physicia is the bur edical	that initiated events resulting in deeth) Lest	C	e to (or as e conse	quence of)						1		
9 x	sath certificate be executed attending physician and for use as the burial-transit clan/Medical Examir												
Boy	th ce rendi		d								1		
	the atter hed for u	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death?				ath?
P.0	ta tac								1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknow				nown
	be d			5 T- 10									
Records,	The law requires cate has been sign page 2 should be									s an autopsy tormed?	ava	ere autopsy findin ailable prior to	
ec	has be ge 2 sh						-				of	mpletion of cause death?	1-
œ	The I								10	Yes 2X No	10	Yes 2 No	
Vital	certificate rector, pag	25. Was case referred to medical examiner?					26. Place	of Deat	h (Check only	one)			
2	Physician: this certific ral director,	1 ☐ Yes 2 ☑ No	Hospitel: 1 Inpatient	2 ER/Outpatie	ent 3 D	OA Oth	ner: 4 🗆 Nu	irsing Ho	me 5X Res	sidenca 6 Oth	er (Specif	y)	
1 0	g Ph ler th neral	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Dete of Injury (Month, Dey Y	ear) 28b. Time Injury	of	28c. Injui Wor	y at	Will	28d. Describe	how injury occurr	bet		
0	Attending or death.  Ctor: Atterby the fune by the fune	2 Accident investigation			М		Yes 2	No					
Division	after death. I Director: After the in by the funers:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, ferm, s	treet, facto	ry, office				(Street end Numb	er or Rura	I Route Number,	
Ö	al or Attending P is after death. In Director: After t ed in by the funers Certification:												
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by Medical Certifi	(Check only 2 Medical Exam)	afcian: To the best of m	amination and/or i									
	within 2 To the I complet	29b. Signature end title of certifier	end menner stated	J.	26	c Licens	e number			29d. Dete signed	d (Month	Dev. Year)	
	F * F 8	A COLOR	Mr-	_									
	4	serve				4501	4			October	2, 2	2000	
		30. Name and address of person who co				-				00303	0.		
		Isabella Martire, 31. Date filed (Month, Dey, Year)	M.D., 83/9		Lane,	Lau	rel,	Mary	Land	20/07-48	31		
	State   Registrar	OCT 6 3 20	10	La La	1	a. V							

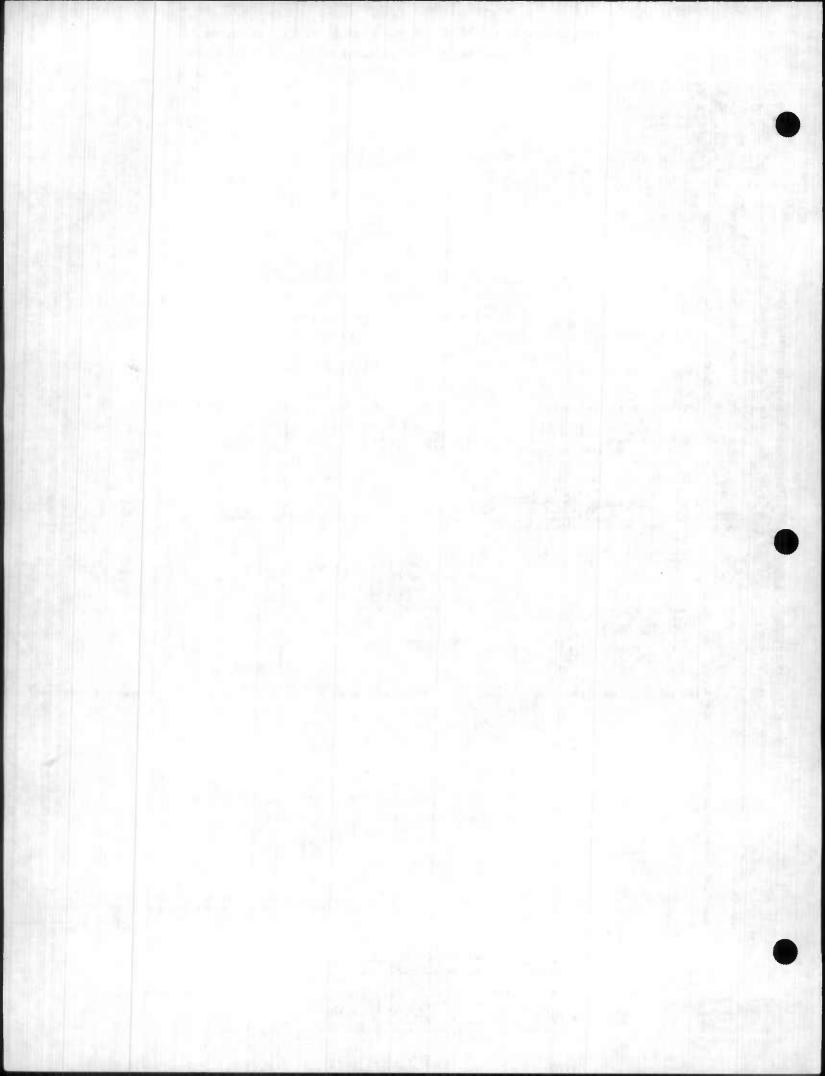


00-5617-031 SEAN BURKE JW

#### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

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).	U	U	J	-	1	U	-

23a,b,27 per me G788 10, 1. Decedent's Name (First, Middle, Las		Certinica	te of Death	2. Dete of			3. Time of Death
SEAN DAVID BURKE				OCTO	BER 03,20	OO O	3:16 P.M.
4e Facility Name (If not institution, give HOLY CROSS HOSP	ATTEMPT TO SEE			wn, or Location of Do		of Death	Y
294-84-1406	7. Age (In yrs.	last birthdey) If Und Months	or 1 Year If Under 1 Deys Hours	Min (Month	Birth Dey, Year) 20, 1986	9. Birthple Country Ohio	ce (State or Foreign y)
Usuel Residence of Decedent  10a. Stete 10b. County	10c. Ci	ty, Town or Location				100	d. Inside City Limits
Maryland Montgome:	Rus	tonsville					1 ☐ Yes ※☐ No
10e. Street and Number	Ly Bul		ip Code		10g. Citizen of	What Country	y?
4260 Dunwood Terra	200	20	866		USA		
11. Meritel Status	12. Wes Decedent Ever in U Armed Forces?		edent of Hispenic Origonic Street	gin? (Specify Yes or	1	ce - American	
1 Married 2 Merried 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Yeer or Detes:	1 ☐ Yes		, Fuerto Ficari, etc.,		ck, White, et Whit	
15. Decedent's Ed (Specify only highest gred		16a. Decedent's Us	uel Occupation	t of working	16b. Kind of B	usiness/Indu	stry
Elementery/Secondery (0-12)	College (1-4or 5+)		ork done during most use retired)				
9 17. Father's Neme (First, Middle, Last)		Student	10 Moths	r's Neme (First, Mid	High S		
					uie, maideri Surner	ne)	
John J. Burke	inna Cointi	10h Mailine Addre	Lynn ss (Street and Numbe	L. Dugas	mhas City as Tour	State Zin C	Codel
			ood Terra				
Lynn L. Burke / Mo	other 20b. I	Place of Disposition (No		Dete	20c. Location		
1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State						
4 ☐ Donation 5 ☐ Other (Specify  21. Signeture of Funeral Service License		tropolitan			Alexand		VA
Aames &	Dooley		nd Address of Fecilities J. Col. Iniversity				g, MD 2090
23a. Pert1. Enter the disease, or comp shock, or heart teilure. List only of Immediate Ceuse (Final disease or condition resulting in death)	. CARDIAC ARRHY	ТНМІА					Approximate ntervel Between Onset and Death
	HYPERTROPHIC (	or as a consequence o					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	D. ————————————————————————————————————	or es e consequence o				1	
Cause (Disease or injury that Initiated events resulting in deeth) Lest	cDue to (c	or es e consequence of	):				
	0						
Pert II. Other significant conditions co	ntributing to death but not res	sulting In the underlying	cause given in Pert I		old tobacco usa co	ontribute to t	the cause of death?
					100	3071000	on a chalowi
					Ves en eutopsy erformed?	com	re autopsy findings lable prior to ipletion of cause seth?
				1	Yes 2 No	10	Yes 2□ No
25. Wes case referred to medical			26. Place	of Death (Check or	nly one)		
examiner?	Hospitel: 1 ☐ Inpatient 2 ☐	NER/Outpetient 3□ I	OOA Other: 4 Nu	ursing Home 5 F	lesidenca 6 DOt	her (Specify)	
27. Menner of Deeth 1 ☑ Netural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?		be how injury occu	rred	
3 Suicide 6 Could not be 4 Homlcide determined	28e. Plece of Injury - At h building, etc. (Speci	ome, term, street, fectory)	ory, office		on (Street end Num Town, Stete)	ber or Rural	Route Number,
	elclan: To the best of my knot lner: On the basis of examine end menner steted.						
29b. Signeture end title of certifier	0 00	2	9c. License number		29d. Date signe		
Venne	Schuk	4	O.C.M.E.		OCTOBE	ER 04,	2000
	depleted cause of death (Ite						
Denms Ch	utem)		Penn Stree			-	

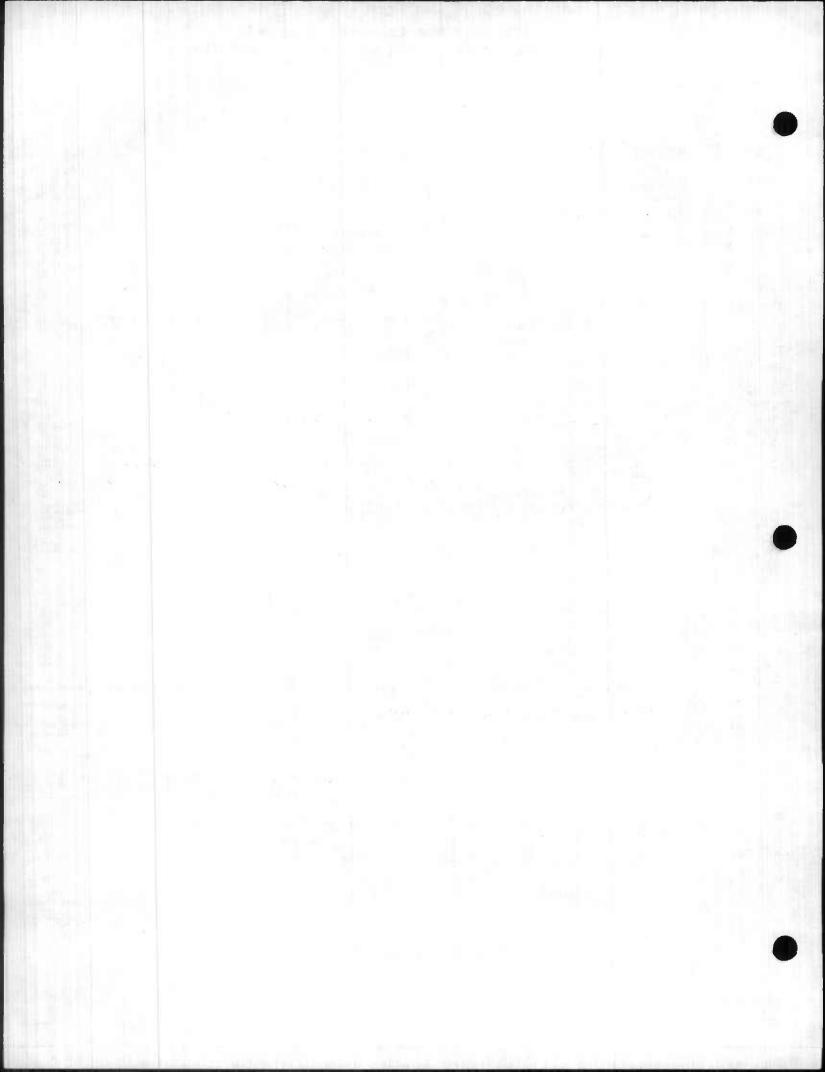


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Deta of Death 3. Time of Death Day Month Year **Physician EDGAR** AUSTIN BAKER SR 2000 6:15 p.m. October 0 /Medical 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Nursing Home Salisbury If Under 24 Hrs Wicomico If Under 1 Year 8. Date of Birth (Month, Day, Year) June 20,1926 5. Social Security Number 7. Age (In vrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Country) Pennsylvania 1 MM 2□ F Yrs. **Director** 222-16-0131 Usuel Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or frems 23s or 28s-f show the Medical Examiner must be notified at Maryland Wicomico 1 Yes 2 No Director Salisbury 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1615 South Kaywood Drive 21804 IISA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☑ Yas 2□ No #Yes, Give Yeer or DateAirForce 1 Never Merried 2 Married Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: p 3 ☐ Widowed 4 ₺ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Reporter Court 17. Fether's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Edgar Benjamin Baker Mary Jane Dorey Nem 27 is man 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health a traportant: If Nem 27 is any Injury or other tra Edgar A. Baker Jr/Son 1615 S. Kaywood Dr., Salisbury, MD 21804 Baltimoré, 20b. Place of Disposition (Neme of 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☑ Other (Specify) Springhill Memory Gardens
22. Name end Address of Fecility 10/5/00 Hebron, MD Entarlament of Funeral Service Licensi Holloway Funeral Home Professional Association M01051 501 Snow Hill Rd., Salisbury, MD 21804 donno 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on limit line. Approximete Intervel Between Onset end Death Physician /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) **Examiner** The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in death) Last and Due to (or es a consequence of): Box 68760 Physician/Medical the Due to (or es e consequence of): signed by the atte Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Be Completed by 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? certificate 1 Yes 1 Yes or Attanding Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4月3 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yas 2 No 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Daeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 ⊠Neturel 2 ☐ Accident 5 Pending To the Hospital or Attanding within 24 hours after death.
To the Funerel Director: Afte completely filled in by the fun 1 Yes 2 No investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Medicai 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) end mannar steted. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier, 29c. License number ma legorio 30. Neme and oldress of person who completed cause of death (Item 23a) (Type, Print) Gregorio Belloso 5302 Chinaberry Drive Salisbury MD 21801 31. Dete filed (Month, Day, Year) 32. Redistrer's Signetura State

**DHMH 16 Rev 6/95** 

Registrar

2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) Month Dev **Physician** BERRY Sept 28 2000 8:15 AM PATRICIA GREENE /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Pines Talbot Genesis ElderCare -Easton If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 20F Months Days Yrs. 226-58-8785 57 11/19/42 Director VIRGINIA Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 77 is marked other than "natural", or items 23s or 28s-f show treumatic avant, the Medical Essential must be notified at 1 Yas 2 No Director SAL ISBURY MD WICOMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 U.S.A. 613 SHERWOOD CIRCLE Pages 1 and 2 should be filed within 72 hours after death 1 ant of Heelth end Mentel Hygiene. Int: If Ham 27 Ia marked other than "natural", or Hema 23. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 [A] No
If Yes, Give
Year or Dates; 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Patricia Berry
Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: WHITE Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Etementary/Secondery (0-12) Coilega (1-4or 5+) DOMESTIC HOMEMAKER 12 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Name (First, Middle, Last) SAMUEL GREENE DELLA MARSHALL 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Raiationship (Type, Print) permit. Pages 1 and 2: Department of Heelth el Important: If Itam 27 la any Injury or other trac MILLARD FILLMORE BERRY, JR. 613 SHERWOOD CIRCLE, SALISBURY, MARYLAND 21804 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Data 20c. Location - City or Town, State 20a, Method of Disposition 1 A Buriel 2 Cremation 3 Removal from State 9/30/00 PARKSLEY, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) PARKSLEY CEMETERY 22. Name and Address of Fecility CCO 385 WILLIAMS-PARKSLEY EY FU VIRGINIA 23421 ft1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory errest, ock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical · Mulignant Nesp Examiner Examiner Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Diseese or injury that initieted events resulting In death) Lest Due to (or as a consequenca of) pue attending physicien for use as the buria 68760 certificata be Physician/Medical Due to (or as a consequence of) Box 23b. Did tobacco was contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. the signed by the 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records, þ 24b. Were eutopsy findings available prior to 24a. Was en eutopsy performed? Completed completion of cause of death? this certificate has page 21 No 1 Yes 2 No Hospital or Attanding Physician: 24 hours after desth. Funeral Diractor: After this certifica Be 25. Was case raferred to medical 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicida 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a Certifier 29c. License number 29d Date signad (Month, Dey, Year) 29b. Signeture and title of certifie WD ROBERT S person who completed cause of deeth (Item 23a) (Type, Print)

Registrar

State

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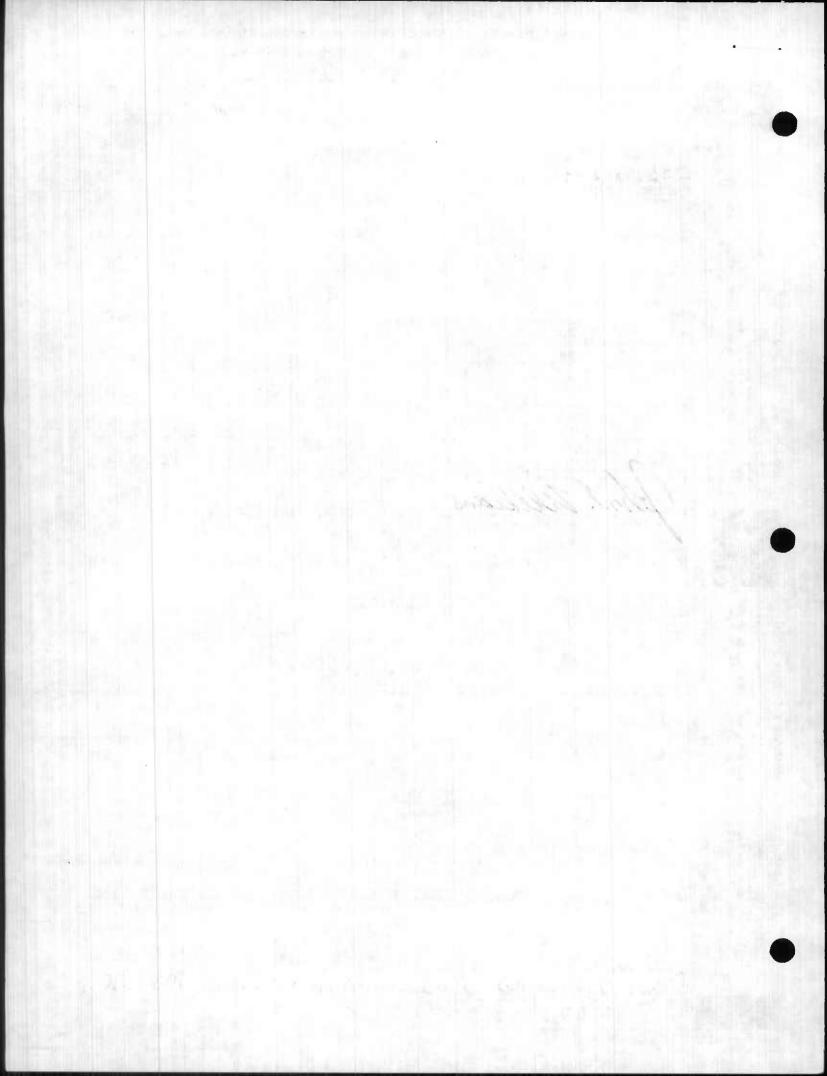
32. Registrar's Signature

SANCHEZ MD

31. Date filed (Month, Dey, Year)

OC 1 0 2

AVENUE EASTON, MD



					Ce	rtificat	e of I	Death			Reg. No.		
444		1. Decedent's Name (First, Middle,	Last)							2. Date of De	ath	.021	3. Time of Death
Physici /Medic		Evelyn Blac	kburn							Month	Day 2	Year	20:52
Examin		4a. Facility Name (If not institution, g	give street and num	ber)			4	b. City, To	wn, or Lo	ocation of Deetl			1
				tospita			(	Camb	orido	L		ches	
Funeral Director		214-14-2878	. Sex 7 1 □ M 2 <b>X</b> ) F	7. Age (In yrs.	. last birthday) Yrs.	Months	Deys	If Under: Hours	Min.	8. Date of Bir (Month, Da OCt.	th ly, Year) 30, 192	9. Birthpl Count Mal	ece (Stete or Foreig try) Cyland
3		Usual Residence of Decedent  10e, State 10b, County		10c. Ci	ity, Town or Lo	ocation						1/	Od. Inside City Limit
n or 28a-f show be notified at	5	Maryland Dorc	hester	, , , ,	.,,			Cam	bri	dae			1 ☐ Yes 2 ☑ N
28a	Director	10e, Street and Number				10f. Zip	Code			- 50	10g. Citizen of \	Whet Coun	
23a or		6104 Twin Poi	nt Cove	Rd.			216	13			7	. A .	.,,
	Funeral	11. Maritel Stetus	12. Wes Deced	lent Ever in U	J,S. 13.	Wes Deced	dent of H	ispanic Orig	gin? (Sp	ecify Yes or No Rican, etc.)	- 14. Rac	e - America	
al', or flams	by Fu	1 ☐ Never Married 2 🖾 Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Deced Armed Ford 1 Yes 2 If Yes, Give Yeer or Dat			1 ☐ Yes		Specify:		rtican, etc.)	Specify	ck, White, e	ite
natur	P	15. Decedent's	Education		16a. Dece	dent's Usua	el Occup	ation	4 -4		16b. Kind of B		
C 3	Completed	(Specify only highest ( Elementery/Secondary (0-12)	College (1~	4or 5+)		kind of wor DO NOT us			or work	ing			
other the	Co	12			Vice	Pres	side				Drape	-	
o o	Be	17. Fether's Name (First, Middle, La Henry Seabrea								ie (First, Middle, ie Mil	, Maiden Sumen	10)	
rsumetic trsumetic	To	-			405 34 15		(0)					and the sales	
T' IS		19a. Intormant's Name/Relationship Ellsworth Carl		bouse							er, City or Town, Caml		2101
Ed		20e. Method of Disposition	yre brac	20b. F	Place of Dispo	osition (Nan	ne of			Date	20c. Location		
y or o		1 ☐ Burial 2 🛣 Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		IATA	mbrid				1	0-07	Cambr		
mportant any injury once.		21. Signature of Funeral Service Lic	1	Car		2. Name an				0-07	Cambi	ruge	, FID
important: If it any injury or o		All all	Tana		n Ci	urrar	n-Br	omwe	11		al Home		
		Dan Part / Enter the disease or co	WASH	wee	30	08 Hi	iah	St.	Ca	mbrida	e, MD	2161	3
ololon		23a Part1 Enter the disease or co	CARLES OF STREET OF	used the deal	th Do not en	ter the mod	le of chile	a such as	cording	mot rac	rroet		
			ly one cause on ea	used the deel ch line.	th. Do not en	ter the mod	le of dyln	g, such as	cerdiac	or respiratory a	rrest,		Approximate Interval Between
	Н	tmmediate Cause (Final	0	1	th. Do not en	ter the mod	le of dyln	g, such as	cerdiac	or respiratory a	rrest,		
dical			a. Can	diopu	lmona	ry A	le of dyln	g, such as	cerdiac	or respiratory a	rrest,		Approximate Interval Between
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Blackburn, Evelyn S.



The same Donners

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) **Physician** ADDIE M. BAKER 0615 SEPTEMBER 29. SOVO /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not institution, give street end number) Examiner WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** Deys Hours 1 M 2 XF 94 222-44-3341 Yrs. Director 9/23/1906 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. inside City Limits 10b. County 1 ☐ Yes 2 ☐No FRANKFORD DELAWARE SUSSEX Directo 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number USA 19945 RT. 3 BOX 198 Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: WHITE ģ 3 Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) HOMMAKING HOMEMAKER 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) important of Health and Mental important if Item 27 is merked on any injury or other traumate. MELISSA BOWDEN SAM BAKER 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) RT. 3 BOX 205G, FRANKFORD, DE 19945 LINDA J. DAVIS 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State 10/4/00 MILLSBORO, DE 4 ☐ Donation 5 ☐ Other (Specify) MILLSBORO CEMETERY 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Tec WATSON FUNERAL HOME, MILLSBORO, DE aleon 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting In death) /Medical (240 neumonia Examiner Due to (or es e consequence ot) Physician/Medical Examine Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es e consequença of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uas contribute to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown Hypoxemia à 24b. Were eutopsy findings evaileble prior to completion of cause of death? 24e. Was an autopsy performed? Be Completed Congestive Heart failure 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 Z No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitei: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Menner of Death 28d. Describe how injury occurred edical Certification: Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29e. Certifier (Check only one) 29b. Signeture and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

M

To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

or 28a-f show be notified at

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than "natural", or liams the Medical Examiner m

Baltimore, Maryland 21215-0020

the death certificate be executed

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Box

P.O.

Division of Vital Records,

physician s the burial

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State Registrar MD

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Salisbury

32. Registrar's Signeture

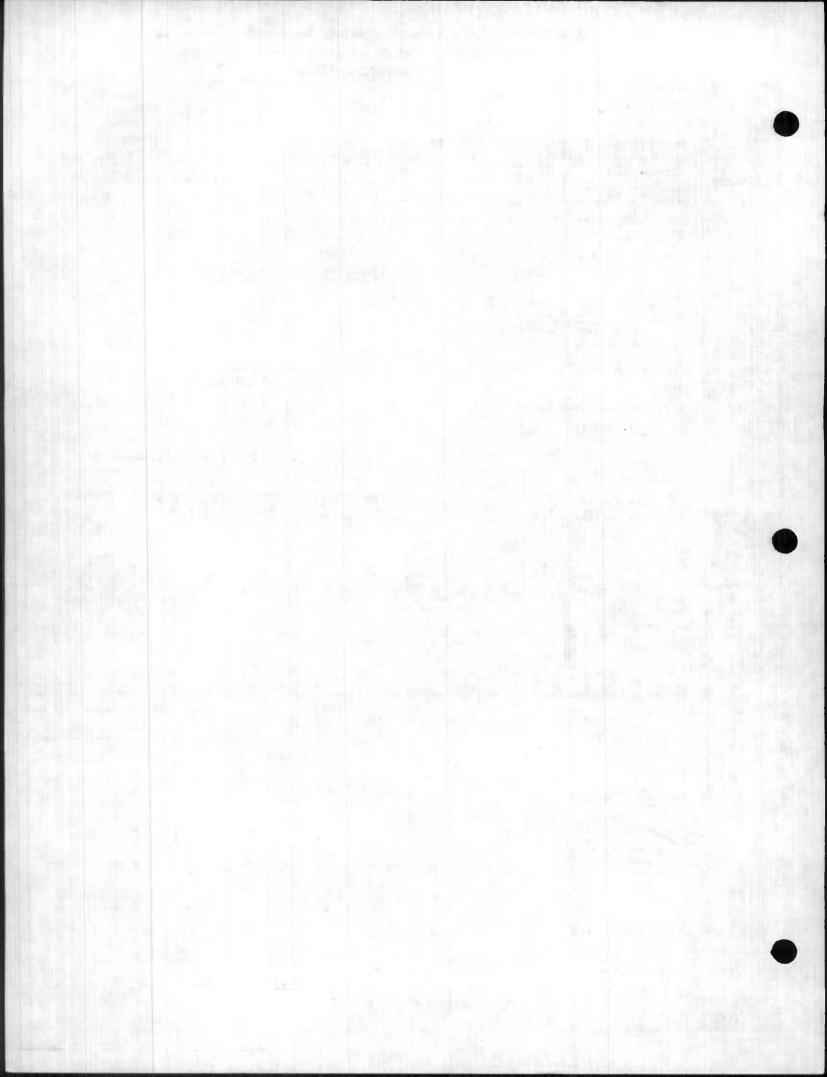
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Robert

COKEN, M.A



	1.1	Decedent's N
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ate of Maryland / Department of Health and Mental Hygiene	00	32757
Certificate of Death Reg. No.		04101

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To the Funeral Director: Attar complataly filed in by the fune of	29a. Certifier (Check only one) 29b. Signeture and	d title of certifien	end m	(H		pe, Print)	0	.C.M.I			Octobe	r 03,	2000

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Dey 5, 2000 Month **Physician** Louis Martin Caspar October 5:29 AM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Deys Hours 110M 2□ F Months 76 11-26-1923 Washington, DC Director 578-22-6816 Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Y Yes 2□No Directo Maryland Charles 28a-f Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? re 23a or 7 23 Elder Place 20640 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Meritel Status Black, White, etc. 72 hours after ICXYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Merried ò 1 ☐ Yes 2 ☒ No Specify: Specify: White Hygiene. other then "natural", o ent, the Medical Exan þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States filled within Elementary/Secondery (0-12) College (1-4or 5+) Government Postal Worker 17. Fether's Neme (First, Middle, Last) 18 Mother's Neme (First Middle Meiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H lant; if Item 27 is marked oth lury or other traumstic even Be George M. Caspar Marie Howard 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 23 Elder Place, Indian Head, Maryland 20640 Shirley May Caspar/Wife 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 10-10 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Veterans Cemetery 2000 Cheltenham, Maryland 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility 20640 Williams Funeral Home, P.A. M00668 4270 Hawthorne Road, Indian Head, Maryland 23a. Pert1. Enter the alleas shock, or head faure. , or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) 5 MINS Examiner Examine allar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): The law requires that the death certificate be execu Physician/Medical Due to (or as a consequence of): 980 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveilable prior to completion of cause of death? should 24a. Wes en eutopsy performed? Completed evene 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case refurmed to medical examiner? Attending Physician: Be 26. Place of Deeth (Check only one) 1 Yes 2 You Hospital: 1 Napatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Neturel 1 Tyes 2 No 24 hours after death.

Funeral Director: A 2 ☐ Accident 6 ☐ Could not be Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) ò Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and menner es stated.

[2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) 29a. Certifier Medicai completely (Check only within 2 the state 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Dey, Year) 10 2000 ed cause of death (Item 23a) (Type, Print) TERRANCE 30. Neme and addr COLLINS, LEUNARD TOWN, HOLLY INDON 6. Box 216 20650

State Registrar 31. Dete filed (Month, Day, Year)

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Baltimore, Maryland

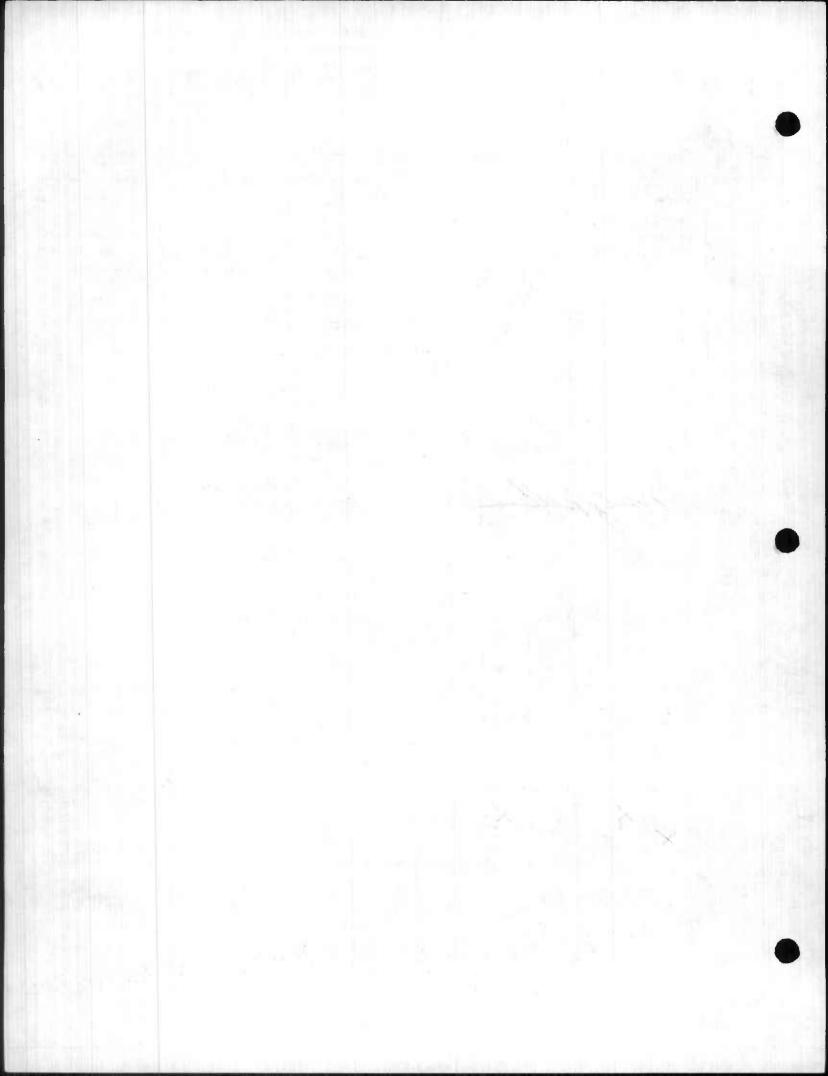
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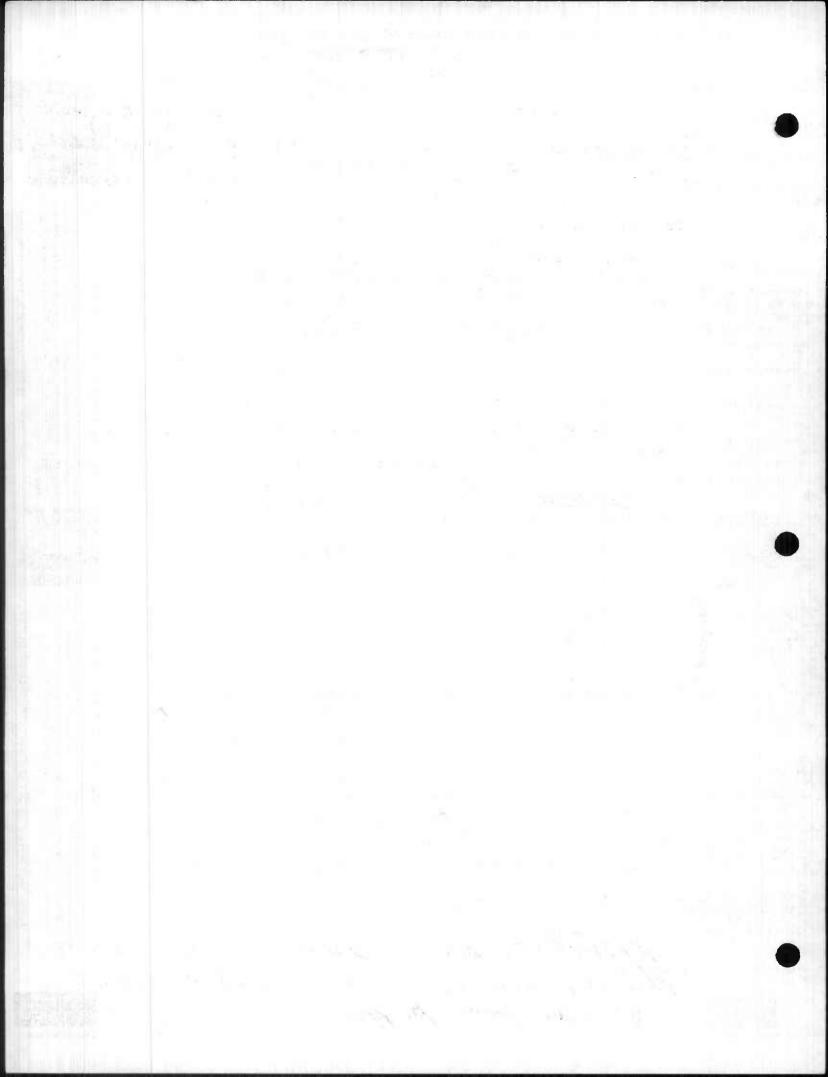
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32. Aegistrar's Signeture



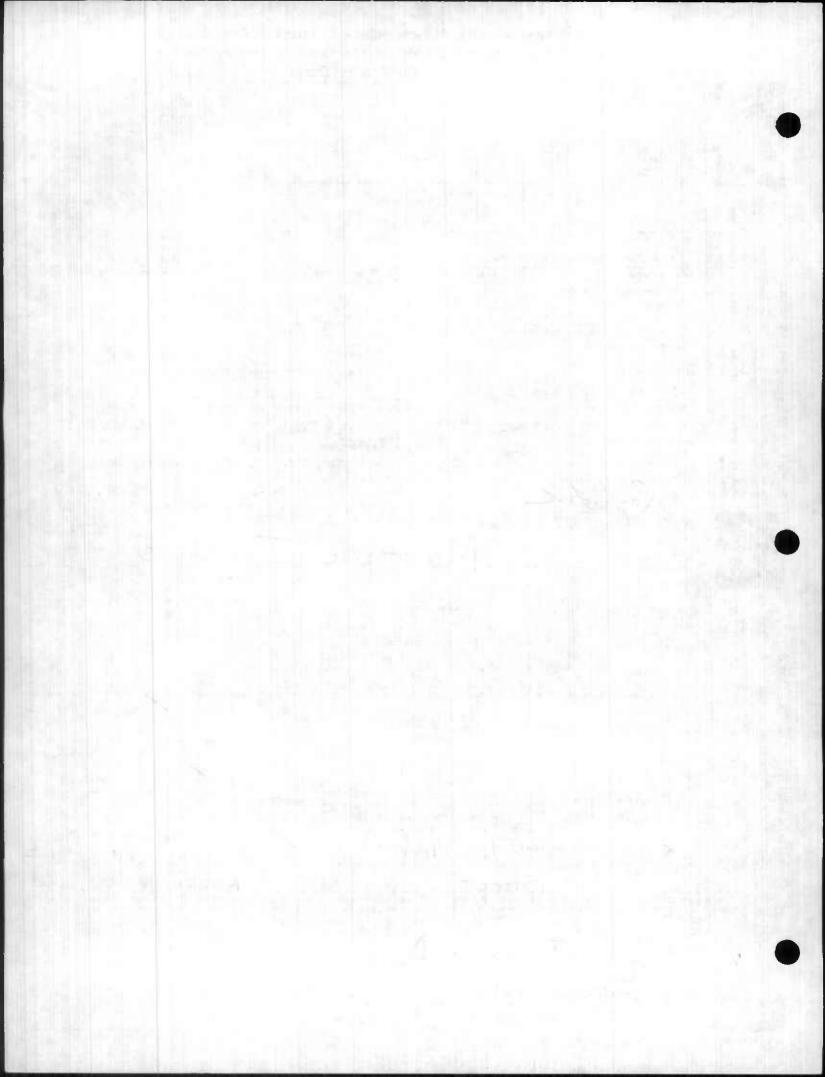
State of Maryland / Department of Health and Mental Hygiene

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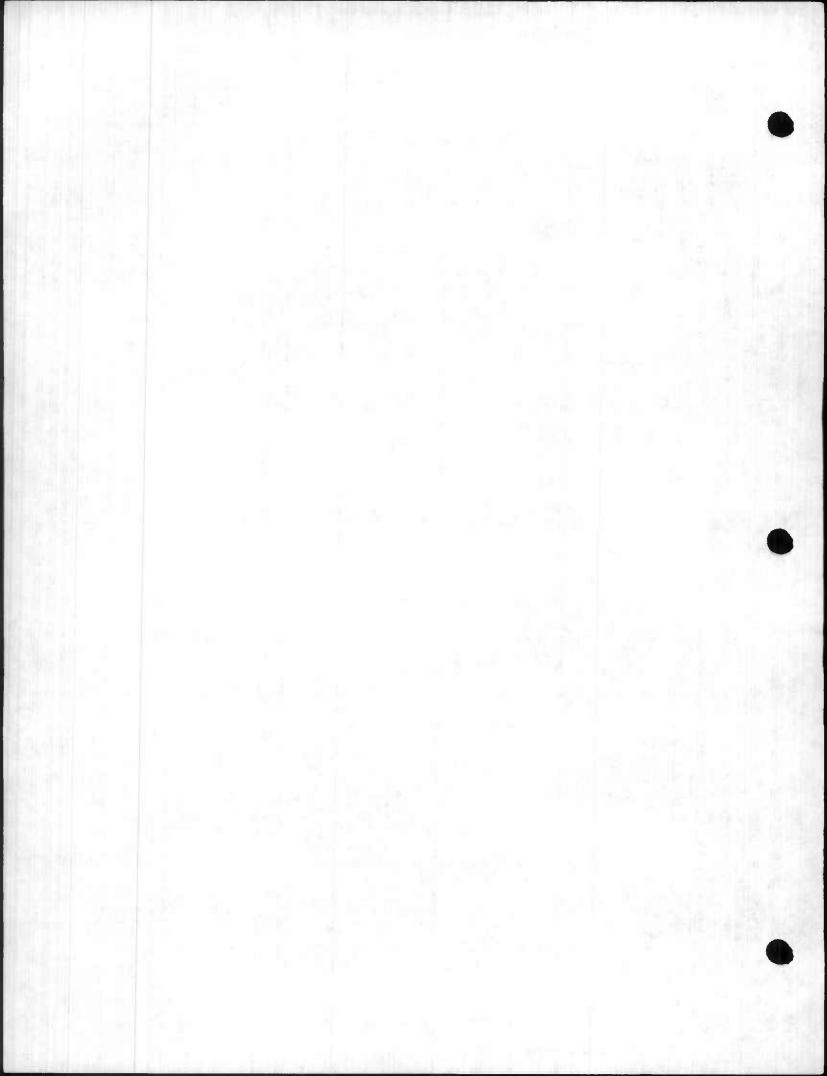
State of Maryland / Department of Health and Mental Hygiene 00 32760

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arylar should by nd Menta marked	1º	Daniel Shelton	Crumpler				De	enise Bake:	r		
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Baltimore, semit. Pages 1 el Department of Hea mportant: if Item any Injury or otherance.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation	2 Demoval from St	CI	lace of Dispos emetery, crem	ition (Name of atory or other pl	(ace)	October	20c. Locatio	n - City or To	own, State
Pages ment of in it is i	)	4 Donation 5 Other (Sp.			gomery	Crematori	um, Inc.		Bethes	da, Ma	ryland
Baltimo permit. Pages Department of Important: If It any Injury or pages.		21. Signature of Funeral Service L	icensaa			Name and Add			/= 1 1:		
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2.0	Data of Death	3. Time of Death
Certificate of Death	Reg. No.	05101
ate of Maryland / Department of Health and Men	tal Hygiene	32761

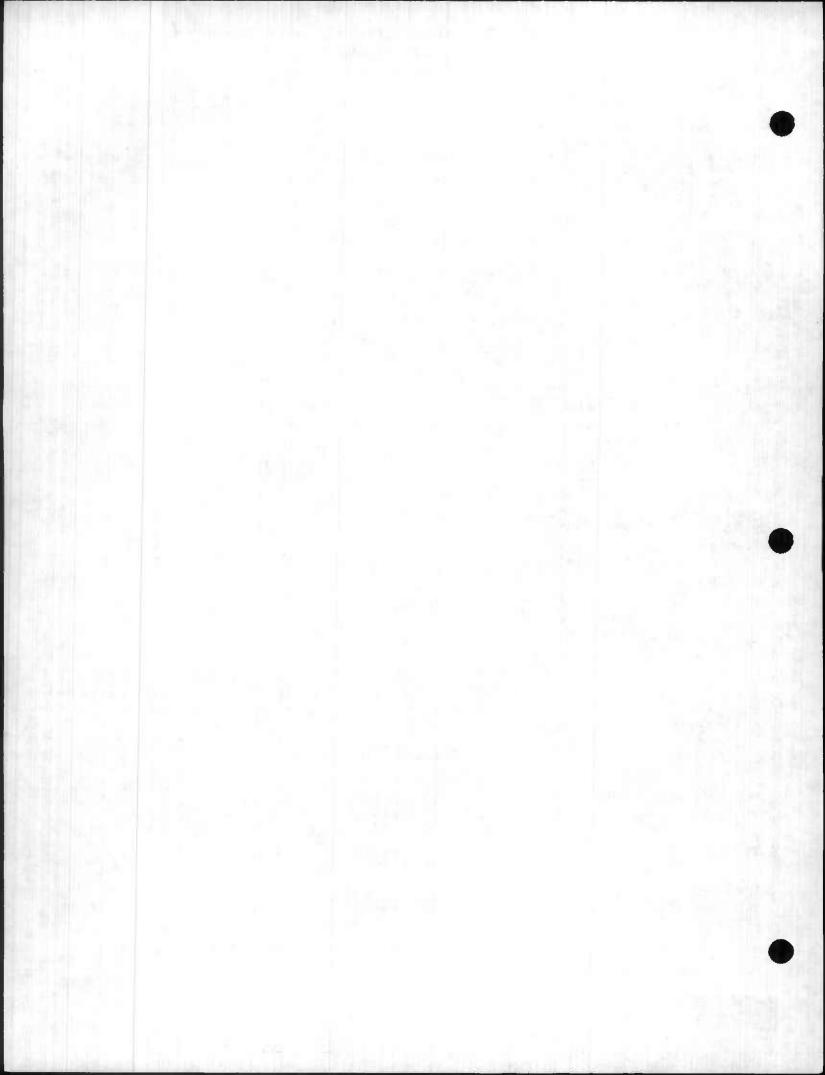
		Olato of Mary		Certificate of	Death	R	eg. No.	1 32/61
Dhisis	1. Decedent's Neme (First, Middle, La	st)		West of the		2. Data of Dear	th Day	3. Time of Death
Physiciar /Medica	Harold F Cropp	er			Marie John	Sept 30		5:45 PM
Examine	do Cantita blama /// and incitation who	re street end number)			4b. City, Town, or I	ocation of Death	4c. County	of Death
	Springbrook Adv	entist Nursi	ing Ho		Silver			tgomery
Funeral	5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birt	Months Day		8. Date of Birth (Month, Day)	Year)	Birthplace (State or Fore Country)
Director	278-18-7371	ZUM ZUF	77	rs.		May 9,	1923	Ohio
pus *	Usuel Residence of Decedent  10a. State 10b. County	100	c. City, Town	or Location				10d. Inside City Limi
Apply and a								1 ☐ Yes 2 💢
or 28s-f sh be notified.	Maryland Montg	omery	Silve	r Spring		1	Og. Citizen of V	What Country?
2 - 4 -		Dr		2090	11		USA	
Ther death v r herns 23s siber chast	11. Marital Status	12. Was Decedent Ever	in U.S.	13. Was Decedent of		pecify Yas or No-		e - American Indian,
There alone	1 Never Married 2 Married	Armed Forcas? 1 ☐¥es 2 ☐ No				o Rican, etc.)	Blac	ck, White, etc.
O20		If Yes, Give Year or Dates:	WW II	1 ☐ Yes 2 💢 N	Specify:		Specify	White
0.5 5 males	15. Decedent's Ed		16a.	Decedent's Usual Occ	upation	tina	16b. Kind of Bu	usiness/Industry
1 21215-0 ed within 72 ho yglene. ser than "nature rt, the Medical.	(Specify only highest gra Elementery/Secondary (0-12)	College (1-4or 5+)	_	(Give kind of work don life. DO NOT use reti	ed)	KIII'Y		
21 Salan Sal	12		Cr	iminal Inv			U.S.	
Du	17. Fether's Name (First, Middle, Last,				18. Mother's Nar	ne (First, Middle, i	Maiden Sumem	Θ)
yla Mental		r				0. Harve	-	
Maryland 21215-0020 d 2 should be filed within 72 hours at the and Mental Hygiene. 7 is merised other than "natural", or treumatic event, the Medical Exam	19a. tntorment's Neme/Relationship (			Meiling Address (Stre				
40 mm day no.	Anna I. Cropper			1119 Lockwo				
altimore, mit. Pages 1 as partment of hea portant if them: y injury or other	20e. Method of Disposition  12 Burial 2 Cremetion 3	Removal from State	cemeter	Disposition (Name of y, cremetory or other p			20c. Location -	City or Town, Stete
time Pa	4 □ Donetion 5 □ Other (Specif		Arlin	gton Natio		/10/00		ton, VA
Sal separation of the separation of the separati	21. Signature of Funeral Service Licer		0					neral Home
W GOTEG	Many	Donnel	V V	11800 Ne	w Hampshi	re Ave, S	Silver	Spring, MD 20
	23a. Pert1. Enter the disease, or com shock, or heert failure. List only	plications thet caused the one cause on each line.	death. Do r	ot enter the mode of d	ying, such es cardia	or respiratory arr	rest,	Approximate Interval Batween
Physician								Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition	Chronic	renal	. failure				5 years
	resulting in deeth)	Dua	to (or es e	consequence of):				
p ti		Congest	ive he	art failur	е			5 years
60, be executed sician and burial-transit	Sequentially list conditions, if any, leeding to immediate			onsequence of):				
cate be exphysician the buria	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	<sub>c.</sub> Diabete	s mell	itus			V-1	10 years
SP Cate	thet initiated events resulting in death) Lest	Dua	to (or es a c	onsequence of):				
Certifi ding isa a		d						
Box 6 eath certifi						ant Dida		
P.O. nat the de d by the setsched	Pert II. Other eignificant conditions of	contributing to death but no	ot rasulting in	the underlying cause	gven in Peri I.			ntribute to the cause of dea 3 Probably 4 ② Unkn
S, P es that es that be determed by the determinant by the de							2LI NO	SE Probably 4 & Onkin
of Vital Records, P.O. Box Physician: The law requires that the attending this certificate has been signed by the attending all director, page 2 should be detached for usa						24a. Was a	an autopsy	24b. Ware autopsy finding
cord require been si should				1000		perlor	med?	available prior to completion of cause of death?
The law						1 🗆 Y	es 200 No	1 ☐ Yes 2₺ No
Vital I	25. Was case referred to medical				26 Place of Do	ath (Check only or	VI	10 165 220 140
Of Vita Physician: this certific ral director,	axaminer?	Hospital: 1 ☐ Inpatient	2 ER/Ou	tpatient 3 DOA	\u.	fome 5 ☐ Resid		ner (Snecifu)
Phys r this eral d		28a. Date of Injury	28b. 1	ime of 28c. In		28d. Describe h		
oding sding : Afte e fun	1 ⊠Neturel 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Ye	ear) li		Yes 2 No			
Division of Attending after death. I Director: After d in by the fune	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of injury -	At home, fa	rm, street, fectory, offic	e	28f. Location (S City or Tow	itreet and Numb	ber or Rurel Route Number,
O Partie	4 🗆 Homicide	building, etc. (S	респу)			City of Tow	ni, State)	
Division C To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funera	29a. Certifier 1⊠ Certifying Pt	nyelclan: To the best of m						
he He he Fu pleta	one)	niner: On the basis of exa and manner stated.		vor investigation, in my	opinion, death occi	irred at the time, o	date end piece,	end due to the cause(s)
To the Hospital within 24 hours a To the Funeral I completaly filled	29b. Signature and title of certifier	A		29c. Lice	nse number		29d. Date signe	d (Month, Dey, Year)
12	tane M.	200	OM	DI	43237	1 1 1	Octobe	r 3, 2000
	30. Nema and address of person who	completed cause of death	(Item 23e)	Type, Print)				
Ele Cle L	Paul Armstrong, 1	M.D. 14201	Laure	Park Driv	e, #102,	Laurel,	Marylan	id 20707
State	31. Date filed (Month, Day, Year)	32. Registrar's	Signatura		,			
Registra	OCT 0 4 20	UU press	1	. Spork	2			



State of Maryland / Department of Health and Mental Hygiene

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					Certificat	e of	Death			Reg. No.		06106
		1. Decedent's Name (First, Middle, L	ast)		1000				2. Dete of Dec			3. Time of Death
	Physician	Elizabeth .	Jane Corl	ev					Month October	2 20	OOO Year	4:00AM
	/Medical	4a Facility Neme (If not institution, g					4b. City, To	wn, or Lo	cation of Deeth		unty of Deeth	
	Examiner	11828 Charles R										
_				e (In yrs. last birtho	lav) If Under	1 Yeer	S1IV(		pring 8. Date of Birt		ntgome	. I (Ot-t F'
	Funeral	214-48-8830	1 M 2 S F	70 Yr	Months	Days	Hours	Min.	(Month, Day	Year)	O TIO	place (State or Foreign intry) hington, DC
ľ	Director .	Usual Residence of Decedent		70					March 1	.5, 19	υ was	nington, DC
Pug	3	10a. State 10b. County		10c. City, Town o	or Location						——— Т	10d. Inside City Limits
aryl	show											1 ☐ Yes 2 ☑ No
9	oct of	Maryland Montgo	mery	Silver		2101						77
it	be notited Director	10e. Street and Number			10f. Zip	Code				10g. Citizen	of Whet Cou	intry?
÷ ÷	2 2	11828 Charles Ro	oad			209	06			USA		
d 21215-0020 filed within 72 hours after death with the Manyland	natural', or tema 23a or 28a-f sho idical Examinat must be notitied at eted by Funeral Director	11. Marital Stetus	12. Was Decedent Armed Forces?	Ever in U,S.	13. Was Deced	dent of I	lispanic Ori	gin? (Sp	ecity Yes or No- Rican, etc.)	14.	Race - Ameri Bleck, White	
O ette	A T	1 ☐ Never Married 2 ☒ Married			1□ Yes		Specify:					hite
005 Urs	by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		10100	220 140	эрвену.			Spi	scny. W	ITTCC
21215-0020 d within 72 hours af	ygiana. Net than "natural", or nt, the Madeal Every Completed by F	15. Decedent's (Specify only highest of	Education	16a. D	ecedant's Usua	al Occup	oation	t of work	ina	16b. Kind o	of Business/II	ndustry
21 Thin	The state of	Elementary/Secondary (0-12)	College (1-4or 5	(i+)	Give kind of worde. DO NOT us			. 01 140111	"'9			
12 W D	or the	12			Сору	Edit	tor			Feder	al Gov	vernment
ם ا	d other	17. Father's Nema (First, Middle, La.	st)				18. Mothe	er's Nem	e (First, Middle,	Meiden Sur	meme)	
lan ed be	Menta artic e To E	Lloyd W. Winebe	erg				Isa	abell	L McQuov	m		
Maryland	and Mental Hygiana. Is marked other than raumatic event, pre M To Be Comp	19a. tnforment's Neme/Ralationship	(Type, Print)	19b. N	failing Address	(Street	end Numb	er or Run	el Route Numbe	er, City or To	wn, State, Z	ip Coda)
M 2	trai	Frederick W. Con	lev / Hush	and 118	28 Char	·1es	Road	. Si	lver Sp	rino.	Marv1	and 20906
Te, M	E E E	20e. Method of Disposition	1200	20b. Plece of D	isposition (Ner	ne of		, ,	Date		on - City or T	
0 88	5 2 6	1 ☑ Buriel 2 ☐ Cremetion 3			cremetory or o		1	10	/ /			
Baltimore,	Department of Health and Mental Hygiana. Innocrtant: if item 27 is marked other than 'may injury or other traumatic event, the Manna of the Mental Compiler.  To Be Compiler.	4 Donation 5 Other (Spec		Parkla								faryland
33	ny ir	21. Signature of Fruneral Service Lic	enses		22. Nama en	d Addre	ess of Facili	INES	S-RINALD	I 118	00 NEW	HAMPSHIRE
Bas 0.	0200	hat IS	11410	2					ING, MAR			
		23a. Part1. Entar the disease, or co shock, or heart failure. List on	mplications that caused	the death. Do no	t antar the mod	le ot dyi	ng, such as	cardiac	or respiratory ar	rast,		Approximate Intervel Between
Ph	ysician		,									Onset and Death
100	Medical	Immediata Causa (Final disease or condition	Metas	tatic si	onet ri	no :	adeno	arci	inoma of	colo	n	7 months
Ex	aminer	resulting in death)	a	Due to (or as e co			auciio	Jul C.	Liioma Oi		1	/ MOHENS
	ě		Colon	cancer	naequanos ory.							1.5 years
uted	physician and s the buriel-transit edical Examiner	Convention the ties constitutes	b	Due to (or as e co	needilance of/.							1.5 years
. Box 68760, death certificate be executed	EX8	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Due to (or as e co	naequanos oty.							
68760,	sicia bur	Cause (Disease or injury	c	Del 1. 7. J	THE WILL A.							
Se licat	ing physicia a as the bui	resulting in death) Last		Due to (or as e co	isequence or):							
X	usa as		d									
Bo	d by the ettend stached for us Physician/											
	the hed	Pert II. Other significant conditions	contributing to death b	ut not resulting in t	he underlying o	ause gi	ven in Part		23b. Dld 1	obacco use	contribute	to the cause of death?
P.O.	detached detached	Diabetes							10	Yee 20 P	No 3 Pr	obably 4 Unknown
S,	E 2 5					511					1	
Records,	page 2 should	TOTAL CONTRACTOR								an autopsy rmed?	a	Vere eutopsy tindings
e C	2 sh										0	completion of cause of death?
	page page								101	res 2KIN	lo 1	☐Yes 2₺ No
-	certificate rector, pag	25. Was case reterred to medical					26. Pleca	a of Deet	h (Check only o	ne)		
of Vita	(A TS	axeminar? 1 ☐ Yas 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outp	atient 3 DC	DA Ot	hor:		ome 512 Resid		Other (Spec	e(fv)
	5 2	27. Manner of Death	28e. Data of Inju (Month, Da		ne of 2	28c. Inju			28d. Describe			,
O D	After fune	1 Neturel 5 Pending 2 Accident investigat		y Year) Inju	ury M		rk? ]Yes 2□	No				
Vision	er death. ector: A by the f	3 Suicide 6 Could not	be 200 Diago of Ini	ury - At home, tem	street tactor	v. office		-	28f. Location (S	Street end N	lumber or Ru	ral Route Number,
-	2 2 2	4 Homicide determine	building, ef	. (Specify)					City or Tov	vn, Stete)		
Pite		29a, Certifier 11x Certifying I	Shusialan, Taitha hasti	d multipoute des	tooth coursed	at the ti	me date se	od alaza	and due to the		d ============	ateted
9	within 24 hours af To the Funeral D completely filled in Medical Cel		Physician: To the best of aminer: On the basis of	axamination and/	or investigation	, in my	opinion, des	th occur	red at the time,	date and pla	ace, and dua	to the causa(s)
å	Mec Mec		and manner ste	1180.	29/	Licen	sa number	-		29d Date si	inned (Montt	n, Dey, Year)
٩		29b. Signeture and title a cartifier	10 //		290							
	12	Lind.	11/20	nell		р35	5996			Uctob	er 3,	2000
		30. Name and address of person wh	*							1 - 1		
		Linda M. Burrel		30 Unive	rsity B	lvd	., #4(	JO, T	wheaton,	Mary	Land	20902
	State	31. Data filed (Month, Day, Year)		ar's Signature	Som	d						
	Registrar	OCT 0 4 20	100 Jan	0.	popol							



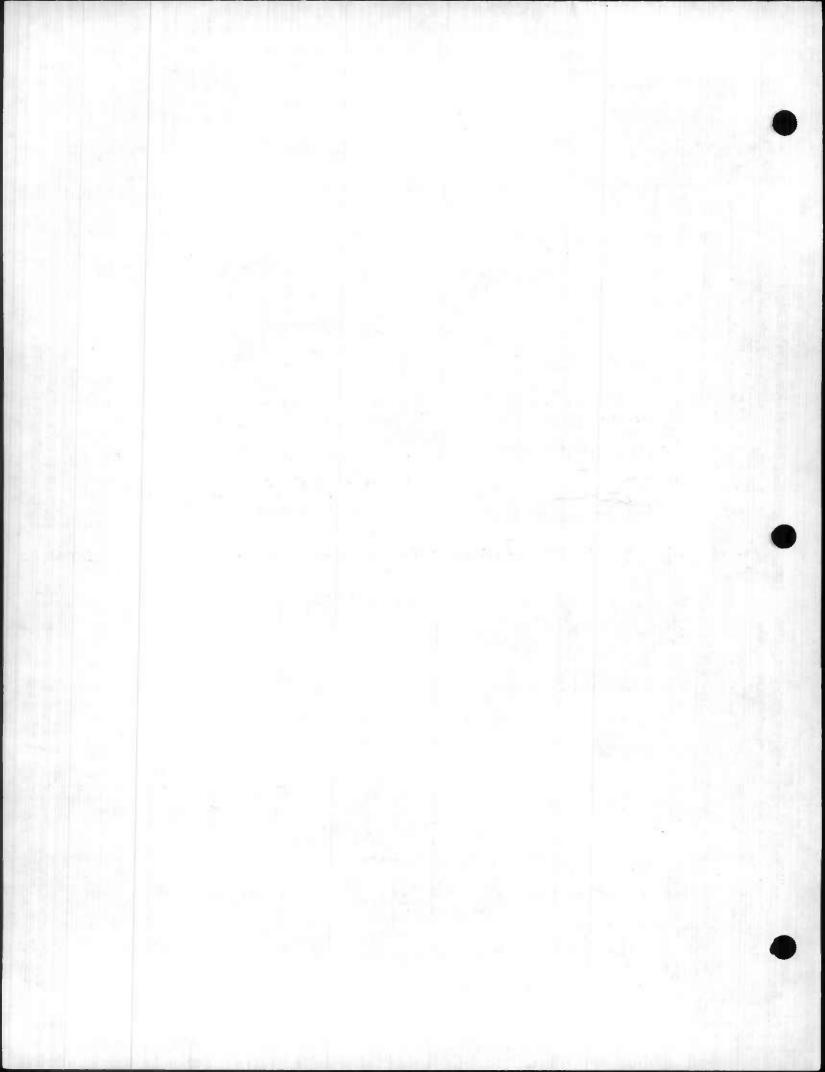
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Beg. No.

32763

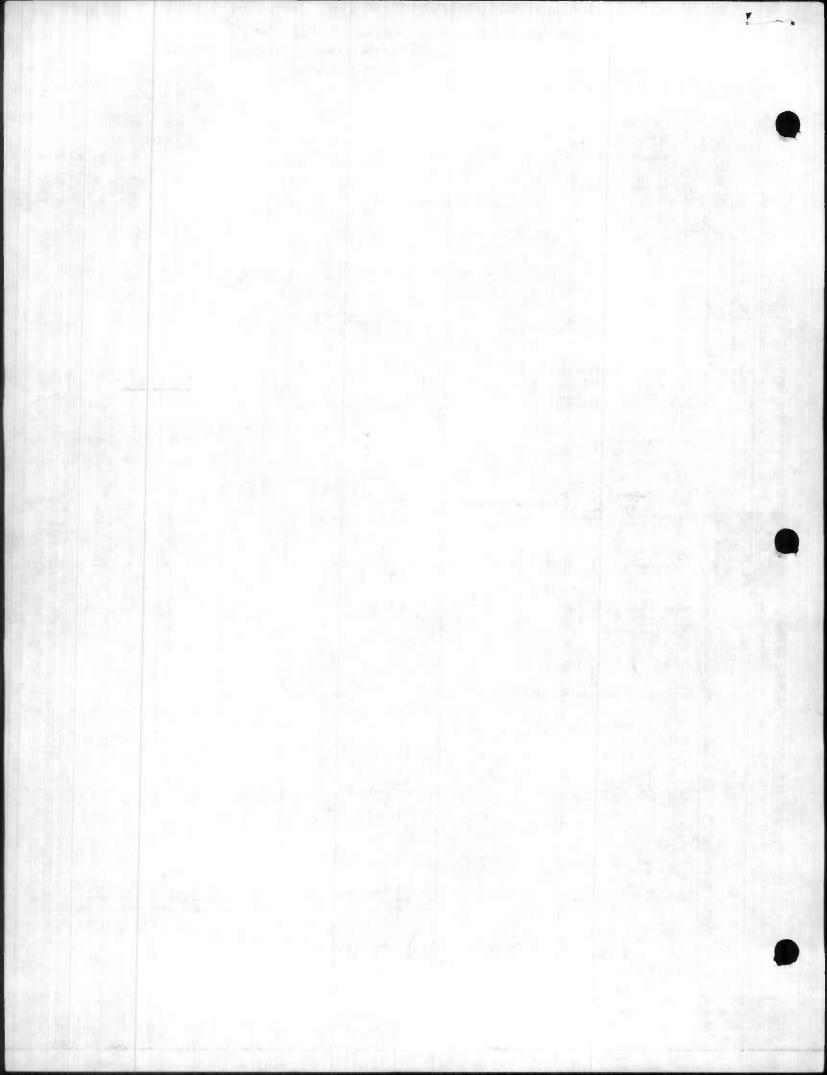
	Certificate of Death	F	Reg. No.	06100
	Decedent's Neme (First, Middle, Last)	2. Date of Dea		3. Time of Deeth
hysician /Medical	James Cooperman	Septembe	er 28, 200	0 6:00am
xaminer	4e Facility Neme (Il not institution, give street end number)  4b. City, Tow	n, or Location of Death	4c. County of De	eath
	9106 Brierly Road Chevy	Chase	Montgo	merv
eral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	4 Hrs. 8. Date of Birth		Birthplaca (State or Foreign Country)
tor	194-05-5313 12 M 2 F 87 Yrs. Months Deys Hours		4. 1912	
•	Usuel Residence of Decedent	2.0 / 5.11.0	17.2	Temmsyrvan
	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
cto	Maryland Montgomery Chevy Chase			1 ☐ Yes 2 🛱 No
Director	10e. Street and Number 10f. Zip Code	1 30-11	10g. Citizen of Whet	Country?
al	9106 Brierly Road 20815		United St	ates
Funeral	11. Meritel Stetus  12. Wes Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican,	in? (Specify Yes or No-	14. Race - Al Bleck, W	merican Indien,
F	1 Never Merried 2 Married 1 Yes 2 No Hyes, Give 1 Yes 2 No Specify:	, , , , , , , , , , , , , , , , , , , ,		
٥	3 ☐ Wildowed 4 ☐ Divorced Yeer or Detes:		Specify: W	nite
teo	15. Decedent's Education 16a. Decedent's Usuel Occupation (Specify only highest grade completed) (Give kind of work done during most of the complete of the co	of working	16b. Kind of Busine	
Completed	(Specify only highest grade completed)  (Give kind of work done during most of life. DO NOT use retired)  (Give kind of work done during most of life. DO NOT use retired)	or working	United S	
5	5+ Chemical Engineer		State De	partment
Be (		's Name (First, Middle,	Meiden Surname)	
0	Jacob Cooperman Ali	ce Gordon		
-	19a. Informent's Neme/Reletionship (Type, Print)  19b. Meiling Address (Street and Number	or Rural Route Numbe	r, City or Town, State	e, Zip Code)
	Tillie Cooperman / Wife 9106 Brierly Road,	Chevy Chase	, MD 2081	5
	20a. Method of Disposition  20b. Plece of Disposition (Neme of cametery, cremetory or other plece)	Dete	20c. Location - City	or Town, Stete
	1 ▼Buriel 2 □ Cremetion 3 □ Removel from Stete 4 □ Donetion 5 □ Other (Specify)  Judean Memorial Gardens	10/02/00	Olney, M	T
	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility			
	Danzansky Goldbe			
	23a. Pert1. Enter the tilsease, or complications that caused the deeth. Do not enter the mode of dying, such as a shock, or heart feiture. List only one cause on each line.			0852 Approximete
Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth)  a.			
Medical E	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last  Due to (or es e consequence of):  C.  Due to (or es e consequence of):			
Physician/	O.  Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.			uts to the cause of dea
		10	Yss 2□ No 3□	Probably 4 Unknown
Completed by			en eutopsy med?	b. Were eutopsy finding eveilable prior to completion of cause of death?
E		101	res 2EINo	1 Yes 2 No
•	25. Was case referred to medical 26. Place	of Death (Check only o	ne)	
0	examiner?   Hospital:	sing Home 5 A Resid		pecify)
-	27. Manner of Deeth 28e. Dete of Injury 28b. Time of 28c. Injury at		now injury occurred	
tio	1 ☑ Neturel 5 ☐ Pending (Month, Dey Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ N	ło		
Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location (S City or Tox		Rural Route Number,
edical (	29e. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end companient of the time, date end companien	place, end due to the oh occurred et the time,	cause(s) and menner date end place, end (	as stated. due to the ceuse(s)
Σ	29b. Signeture end into of certifier 29c. License number		29d. Date signed (Mi	
	D23911		Scotomb	er 28,200
	30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)		-1 / -11/19	10/4
tate trar	0 . 1 0:	Road	Bethesda	MD 208,



State of Maryland / Department of Health and Mental Hygiene

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Amend #18	,10/4/2000,BMW,Monto			e of Death	R	eg. No.	0 32/64
Physiciar /Medica	SIEPHEN		COHEN		2. Data of Deal Month SEPTEMI	Day BER 29,	3. Tima of Death 2000 1:30 AM
Examine	An English, blama // not in stitution when	street and number)		4b. City, Town, o	Location of Death	4c. County of	of Death
Funeral Director	213-78-0619	7. Age (In yrs. 42	Yrs. If Under Months		S. 8. Date of Birth (Month, Day	Year)	9. Birthplace (State or Foreig Country) Washington, D.
/land	Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Location				10d. Inside City Limit
r 28s-f sh notified	Maryland Montgon	nery D	amascus				1 ☐ Yes 2 X N
9 28 2	10312 Bloom Driv	ve .	10f. Zip	Code 20872	1	Og. Citizen of W	That Country? States
ours after death value 23 Examinet must	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates:	S. 13. Was Decedif Yes, spec	lent of Hispanic Origin? ify Cuban, Mexican, Pue	(Specify Yes or No- orto Rican, etc.)	Black	- American Indian, k, Whita, atc. White
ad within 72 ho ygiene. ser than "natur it, the Medical	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)			ol Occupation ork done during most of we retired) er Programm		16b. Kind of Bu	
d 2 should be thad within 72 hours at 7 is marked other than "natural, or treumatic event, the Medical Exam."	17. Fether's Name (First, Middle, Last)	Cohen			ame (First, Middle, i		*) † † 7.
s man	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing Address	(Street and Number or	Rural Route Number	, City or Town,	State, Zip Code)
at the sea of	Elizabeth Joyce			loom Drive,			
mit. Pages 1 a partment of Hea portant if Item; y Injury or other Ste.	20a. Method of Disposition  1 Burial 2 Toremation 3 4 Donation 5 Other (Specify	Removal from State	Place of Disposition (Nan emetery, crematory or o esapeake Cr	therplace) ematory Inc	10-2-2000	Beltsv:	City or Town, State
Depart Depart Import any in	21. Signature of Funeral Service Licent	aman	22. Name an Rapp Step 933	d Address of Facility Funeral an hen D. Lohr Gist Ave.,	d Cremati mann P.A. Silver Sp	on Serv	ices, aryland 2091
Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)  Sequentially list conditions.	Due to (a	Sigmoid Corres a consequence of):	olon Carcin	oma		39 Months
ificate be g physicia es the bur	Cause (Disease or injury that initiated events resulting in death) Last	CDue to (o	r as a consequence of):				
at the death cert d by the attendin etached for use	Part II. Other significant conditions co	ntributing to death but not res	ulting In the underlying c	ause given in Part I.	23b. Did to	obacco uee con	tributa to the cause of deat
es thet the igned by be detacl					1 🗆 Y	•• <b>%</b> No	3 Probably 4 Unkno
The law requires the law requires the las been signed page 2 should be dead by					24a. Was a perfor	in autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
The law ate has bege 2 s					10Y	es 2X No	1 ☐ Yes 210 No
clan: ertific ector.	25. Was case referred to medical examiner?	Hospital:		Othor:	eath (Check only or		,
hys his	TEL TES ZULNO	28a. Date of Injury (Month, Day Year)		8c. Injury at Work?	Home 5 Resid		
tal or Attending P rs after deeth. al Director: After t led in by the funer	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Placa of Injury - At he building, etc. (Specify	ome, farm, street, factory		28f. Location (S City or Tow		er or Rural Route Number,
Hospi 14 hour Funer tely fil		relcian: To the best of my kno iner: On the basis of examina and manner stated.					
within 2 To the comple		0	290	: License number	2	9d. Date signed	i (Month, Day, Year)
15	30. Name and address of person who o	ompleted cause of death (Ifen	700 Y	D07285	S	eptember	29, 2000
	//	M.D.; 9707 Med		r Drive, Ro	ckville,	Maryland	20850
State Registrar	31. Date filed (Month, Day, Year)	32 Registrar's Signa	dues Torre	Kri.			

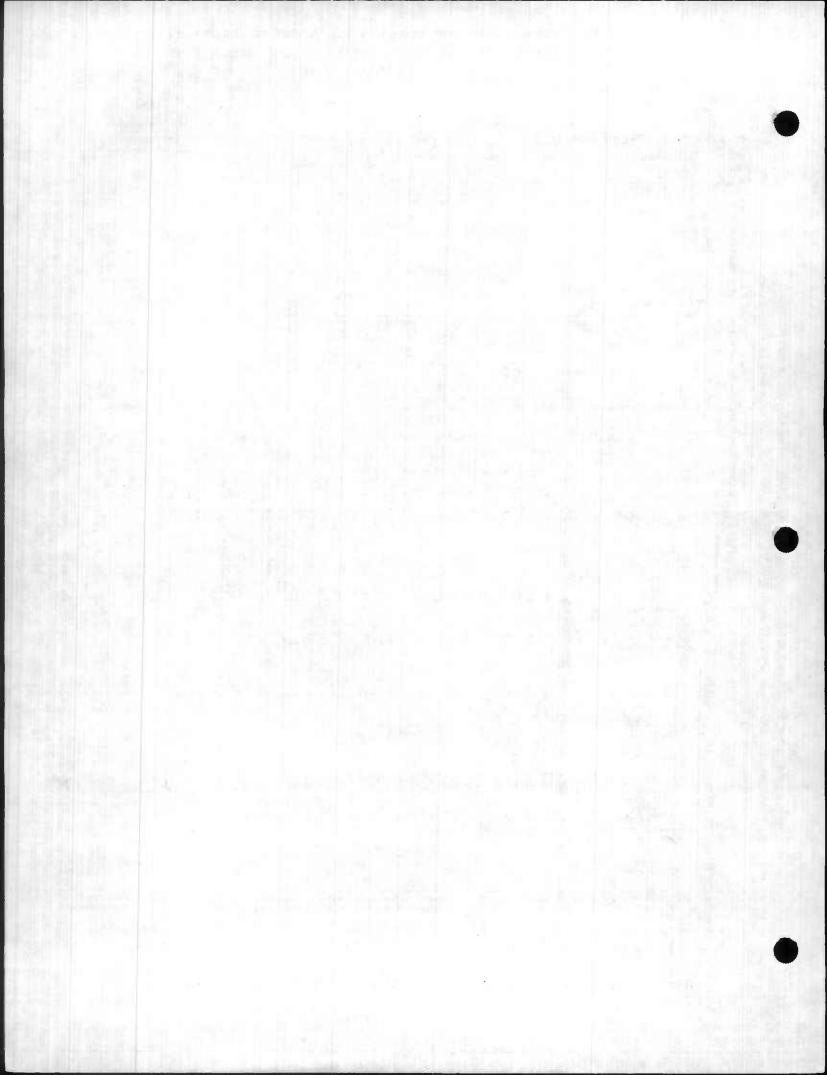


State of Maryland / Department of Health and Mental Hygiene

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				Cei	rtificate of	Death		Re	g. No.		0 6 1 6	
Physician	Decedent's Name (First, Mid Estelle	dle, Last)			Cohe	en		Data of Death	Dey 200	O <sup>Yaer</sup>	3. Time of Dec 2:55 A	
/Medical Examiner	4e Facility Name (If not institut Holy Cross Ho		ımber)				wn, or Loca	ring	4c. County	of Death	y	
uneral irector	5. Sociel Security Number  063-01-6150  Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☐ XF		N yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. Months Deys Hours Min.			Min.	Dete of Birth (Month, Dey, aug. 14,	Year) 1918	9. Birthp Coun New	lece (State or Fo try) York	reign
notifiedat	10a. Stata 10b. Coun	gomery		y, Town or Lo	Spring					1	0d. Inside City L	
2 0	10e. Street and Number 1136 Loxford	Terrace			10f. Zip Code 2090	1		10g. Citizen of Whet Country? United States				
Examiner must by Funeral	11. Marital Status  1 Never Married 2 N M. 3 Widowed 4 Divorce	Armed F arried 1 Tes If Yes G	2 XNo		Wes Decedent of If Yes, specify Cul	oen, Mexican	gin? (Speci i, Puerto Ri	fy Yes or No- can, atc.)		ce - Amaric ck, White, y: Wh		
r, the Medical		ent's Education lest grada completed College	) (1-4or 5+)	(Give	dent's Usuel Occu kind of work done DO NOT use retin	during mos	t of working	1	Inite		dustry tes Govi	n't
ent, the Co	17. Father's Neme (First, Middl			0111	oc ranag	_	er's Neme (i	First, Middle, M			000	10
To Be C	Samuel Samuel		5	Sapers	tein	Len	ıa			M	anius	
T T	19e. Informent's Neme/Reletio	nship (Type, Print)		-	ng Address (Stree	ot end Numbe	er or Rurel I	Route Number,	City or Town,			
art r	Abner B. Coher	h (husban	d)	same	as #10							
or other	20e. Method of Disposition  1 Duriel 2 Cremetion 4 Donetion 5 Other		State	emetery, crei	id Memor		rden		Oc. Location			rgin
eny injury pace.	21. Signeture of Fargeral Sorvice	e Xicensee	Li		nald void							05
sician edical miner	23e. Part1. Enter the disease, shock, or flear feilure. Li  Immediate Ceuse (Fine) diseasa or condition resuiting in deeth)		caused the deeth each line.  Quoudly  Due to le			ing, such es	cardiac or i	respiretory erre	est,	1	Approximete Interval Batwee Onset end Dee	
attending physician and for use as the burial-transit clary/Medical Examiner	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest	6. <u>ld</u>	Due to (o	r es e consec	quenca of):	بر :	7.6	rosis			Year	3
shed for u	Red II Other deplicant and	tions contribution to	lanth hut not mo	ultion in the u		ives in Bart I		22h Did to	hagan was an	meribuse e	o the cause of d	leath 2
be detached for use by Physician/N	Part II. Other eignificant condi	elward	le le	anding in the o	indenying cause g	Neil III Felt I				3 Pro		
should	Reval	clusif	Biccom	1,	0 0			24a. Wes ar parform	n autopsy ned?	ev	ere autopsy findi eileble prior to implation of caus death?	
Раде	heft!	cittula	Heo	05	Janu	4		1□ Ye	s 25 No	10	Yes 20 No	
director, page 2	25. Was case referred to medic examiner?	Manufacture.			10		of Deeth (	(Check only on	ө)			
After this funeral di	1 Yes 2 No  27. Menner of Deeth  Netural 5 Pen	28e. Dete	Inpatient 2   of Injury	28b. Time o Injury	of 28c. Inj		28	e 5 Reside			<u>(Y</u>	
al Director: After t led in by the funera Certification:	3 Suicide 6 Coul	d not be	a of Injury - At ho ting, etc. (Specif)	ome, farm, str	reet, factory, office			St. Location (St. City or Town	reet and Numi n, State)	ber or Rure	el Route Number	;
To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifler Certify (Check only 2 Medic	ring Physician: To the l at Examiner: On the l and me	e best of my know basis of examinations stelled.	wledge, deet tion and/or in	h occurred et the l vastigetion, in my	time, dete en opinion, dea	d plece, en ith occurred	nd due to the ca d et the time, da	ause(s) end mate end place,	enner es s	tated. the cause(s)	
To the	29b. Signetup and title of certi	38	1		25	number &		29	9d. Data signe		Day, Year)	
	30. Neme and address of parson Herman Segal,	M.D. 10313	3 Georgi	a Aver		Silv	er Sp	ring, M	[arylan	d 209	902	
State	31. Dete filed (Month, Day, Yea	32.	Registrar's Signa	iura								

Registrar



					(	Certifica	ate o	of Death	1		Reg. No			2766
1. Dec	cedent's Name (/	First, Middle, La	ist)	11-5						2. Date of De	eath Dav	v	Year	3. Time of Death
	SA	ARAH	GOODE	COG	HILL					10			000	3:351
4a Fa	acility Name (If no	ot institution, giv	e street and nur	m <i>ber)</i>				4b. City, To	own, or Lo	cation of Daat	h 4c.	County of	of Death	
E Can	P.G.	HOSPI	3	7. Aga (In yr.	n land hirdh	ford If Line	dar 1 Yè	CHE	VERL 24 Hrs.	Y Date of Bi	rth	P.G	5 Distanta	on /Ctata or Form
	8-22-8		1□ M 2 F	88	Yr	Month	s Day		Min.	(Month, Da	y, Year)	1012		ca (Stata or Fora v) AROLIN
	i Residence of De									CODI	40,	1312		
10a. S	Stata 10	0b. County			City, Town		-	D.C.					100	d. inside City Lim Yas 2□I
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100. 5	Street and Number		HEIGH	mc ta	ME	101.	Zip Code	0743			Tog. Cit	USZ	hat Countr	yr
11 M	larital Status	DEAVER	12. Was Dece			13. Was Dec			rigin? (Spe	cify Yes or Ne	o- T		- Amarice	Indian,
	☐ Nevar Married	2 Married	Armed Fo 1 ☐ Yes	rces? 21☑ No						ecify Yes or Ne Rican, etc.)			, White, et	c.
3	Widowed 4	Divorced	IT Yes, GIV	If Yes, Give 1 ☐ Yes 2 No Specify: Year or Dates:								Specify:	BLA	.CK
	(Specify		(	ecedent's U	work do	ne during mo	st of worki	ing	16b. K	ind of Bu	siness/Indu	stry		
Ele	ementary/Seconda	ary (0-12)	College (1	I-4or 5+)		6. DO NOT					N	/ A		
6TH FOOD SERVICE N/A  17. Father's Name (First, Middla, Last)  18. Mother's Name (First, Middla, Maidan Surne														
m	JOHN M	CWILL	IAMS					MA	RJIA	NA		(TINII)	KNOWN	1
19a. i	informant's Name	e/Relationship (	(Type, Print) D	AUGHTI	ER 19b. N	Aeiling Addre	ess (Stre	eet and Numb	per or Rura	al Route Numb	per, City o			
19a. Informant's Name/Relationship (Type, Print) DAUGHTER 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  MARGARET G. JOHNSON 2537 HIHG ST. S.E. WASH, DC. 20020														
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State														
										- 1				
	Donation 5	Other (Special		M	IARYL	AND 1	TAV	IONAL		9/00	LAU	REL	, MD	•
	Signature of Fund		fy)	2 M	IARYL	AND N	AT]	IONAL	lity					_
21. S	Signature of Fund	al Service Lice	nsee G. G	Tuck	en	AND N 22. Nama AUST 38.2	and Ad	IONAL dress of Facil ROYS 4TH S	rer rer r. n	FUNERA	AL H		2001	1
21. S		al Service Lice	nsee G. G	Tuck	en	AND N 22. Nama AUST 38.2	and Ad	IONAL dress of Facil ROYS 4TH S	rer rer r. n	FUNERA	AL H		2001	_
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the ettending physician end Apmpletely filled in by the funerel director, page 2 should be detached for use as the buriel-transit Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and placa, end due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the ceuse(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. Licansa number

29b. Signature and title of certifier

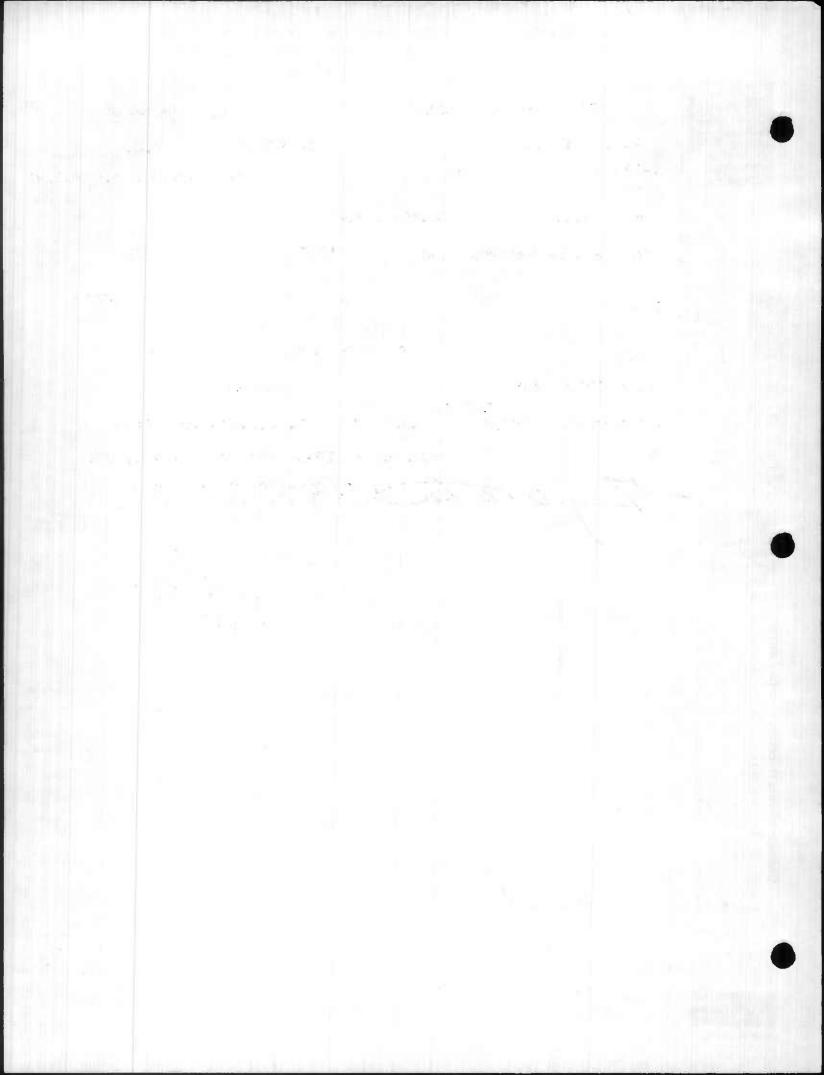
D0055703

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) 3001 HOSPITAL DR, CHEVERLY, MD. 20785

State Registrar

31. Date filed (Month, Dey, Year) **OCT 0 6 2000** 

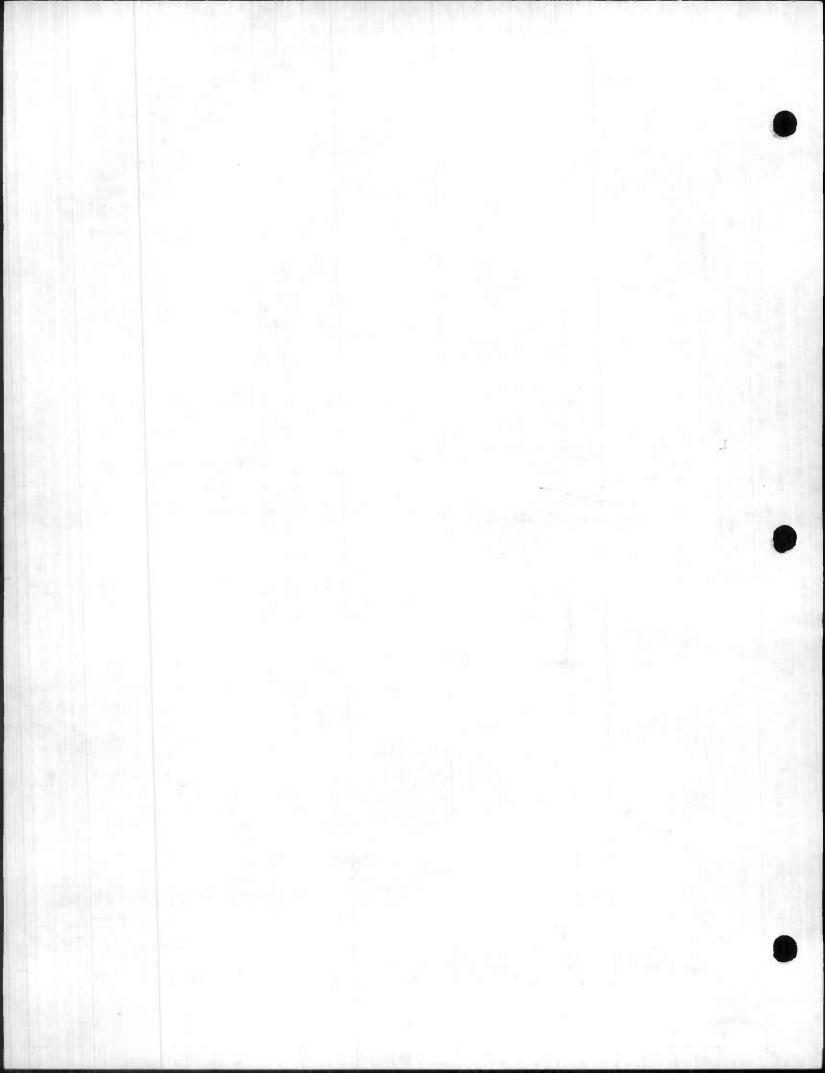
32. Registrar's Signature



ate of Maryland / Department of Health and Mental Hygiene	nn	37767
Certificate of Death Reg. No.	00	06101

			Certifica	ate of Death	R	eg. No.	0 02101		
Physician	1. Decedent's Nama (First, Middle, Last		LEWIS FO		2. Date of Deal		3. Tima of Death		
/Medical		eah Citrin			October	-			
Examiner	4a Facility Name (If not institution, giva Brighton Garde		ckerman Lan	e North Be			of Death gomery		
Funeral Director	5. Social Security Number 098-28-1064 6. Se	7. Age (In yn 92	s. last birthday) If Un Monti	der 1 Year   If Under 24 Hr. is Days   Hours   Min	8. Data of Birth (Month, Day December	Year) 190	9. Birthplace (State or Forei Country) 7 New York		
2 >	Usual Residence of Decedent  10e. Stata 10b. County	100 (	City, Town or Location				10d Incide City I Imi		
ahov ahov				th Bethesda			10d. Inside City Limi 1 ☐ Yas 2 ☑ N		
vith the Ma or 28s-f a be notified	Maryland Montgo	mery		Zip Code	1	0g. Citizen of V	21		
ath with the Marylar 23a or 28a-1 ahon ust be northed at rai Director	5550 Tuckerman L			20852		United	States		
5-0020 72 hours after death with the Maryland natural, or theme 23e or 28e-f show see Example: must be notified at steed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Giva Year or Dates:		cedent of Hispanic Origin? ( pecify Cuban, Mexican, Pua 20 No Specify:	Specify Yas or No- irto Rican, etc.)	Blac	e-Amarican Indian, ck, White, etc. .: White		
1 Z1Z13-002 ed within 72 hours ygiene. or than "natural", rt, me tredied Ex Completed by	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Decedent's U (Giva kind of	work done during most of we	orking	16b. Kind of Bu	usinass/Industry		
d within giene.	Elementery/Secondary (0-12)	College (1-4or 5+)	lifa. DO NO	use retired)					
e filed with the other the vent, the last the vent, the last the vent, the last the vent, the last the	12 17. Father's Name (First, Middle, Last)		Homemake		ame (First, Middle, I	Own Ho			
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should by and Mente of marked imarked imarked	19e. Informant's Name/Relationship (7)		10h Meiling Addr	SODNIE ess (Street and Number or F	Gelfand	City or Town	State 7in Code		
Mar d 2 sho d 2 sho th end 7 le m traum	Cynthia Janis / D			dle Harbor L					
Heal Heal	20a. Method of Disposition		Place of Disposition (	Name of	1		City or Town, Stata		
emit. Pages 1 a Separtment of Hee mportant: If Item iny Injury or other are	1 Buriat 2 Cremation 3 F 4 Donation 5 Other (Specify)		cematary, cremetory		10/04/00	D	NI T		
pemit. Pages 1 and 2 Department of Health e Important: if item 27 in any injury or other tra	21. Signature of Funeral Service-Ligens			k Cemetery and Address of Facility	10/04/00	Para	mus, New Jers		
	1 6		Danza 1170	nsky Goldberg Rockville Pil	ke, Rockv	ille. M			
	23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that caused the de ne cause on each line.	ath. Do not enter the n	node of dying, such as cardio	ec or respiratory arr	est,	Approximete Intervel Between		
Physician ( /Medical Examiner	Immediate Causa (Final disease or condition	Congest	ive heart	disease			Onset and Death		
	resulting in death)  Due to (or es a consequence of):								
executed in end tal-transit		, myocana	ial into	nction		2.2.2	1 month		
physician and sthe burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequence	of):					
2 3 5 m	cause. Enter Underlying Cause (Disease or injury that initiated events	o							
ifficate be available of physician as the burial	rasulting in death) Last	Due to	(or as a consequence of	n):					
		d							
death center of for use	Part II. Other significant conditions co	tributing to dooth but got re	aution in the underlying	a cause sives in Best I	23h Did to	haces upp oo	ntribute to the cause of deat		
t the A	r art ii. Outer significant conditions co	ithouting to death but not re	sourig in the underlying	g causa given in Fait i.			3 Probably 4 (Unknown)		
be de do					-				
requir seen s should					24a. Was a perform	n autopsy med?	24b. Ware autopsy finding available prior to complation of causa of death?		
					1 D Y	as 200 No	1 ☐ Yas 2 ☐ No		
Physician: This certificate rei director, po	25. Was casa referred to medical			26 Place of De	eath (Check only or	- ' '	70.103 20.10		
hysician: The I	examiner? 1 ☐ Yas 2 ☑ No	lospital: 1   Inpatient 2	☐ ER/Outpatient 3☐	Othor	Home 5 Raside		as (Soecity)		
	27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Tima of	28c. Injury at Work?	28d. Dascribe h				
atio	1 Available 1 Accident 5 Pending investigation	(Month, Day Year)	Injury M	1 Yes 2 No					
tal or Attending P is a ther death.  al Director: After tied in by the funare Certification:	3 Suicide 6 Could not be 4 Homicide detarmined	28e. Piece of Injury - At building, etc. (Spec	homa, farm, street, fac city)	tory, offica	28f. Location (Si City or Town		ber or Rural Routa Number,		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funarel director, Medical Certification: To Be	29a. Certifier Certifying Phy (Check only one)	sician: To the best of my kr ner: On the basis of axamir and manner stated.	nowledge, death occurr nation and/or invastigat	ed at the time, data and plac ion, in my opinion, death occ	ce, and due to the courred at the tima, d	ausa(s) and ma ate and piece,	inner as stated. and due to the cause(s)		
o the o the omple omple	29b. Signatura and title of certifier ),	and market dialog.		29c. License number			d (Month, Day, Year)		
15	> Ellen m fin	hout mD		D 51015			ase MD 2081		
	30. Nama and address of person who co		em 23a) (Type, Print)			01	40. 5		
	Ellen M finhout		O Wiscor	win Ave #1	045 Ch	evy Ch.	ase mp 2081		
State	31. Data filed (Month, Day, Year)	32. Registrar's Sig	natura 6	marker		U			

DHMH 16 Ray 6/95

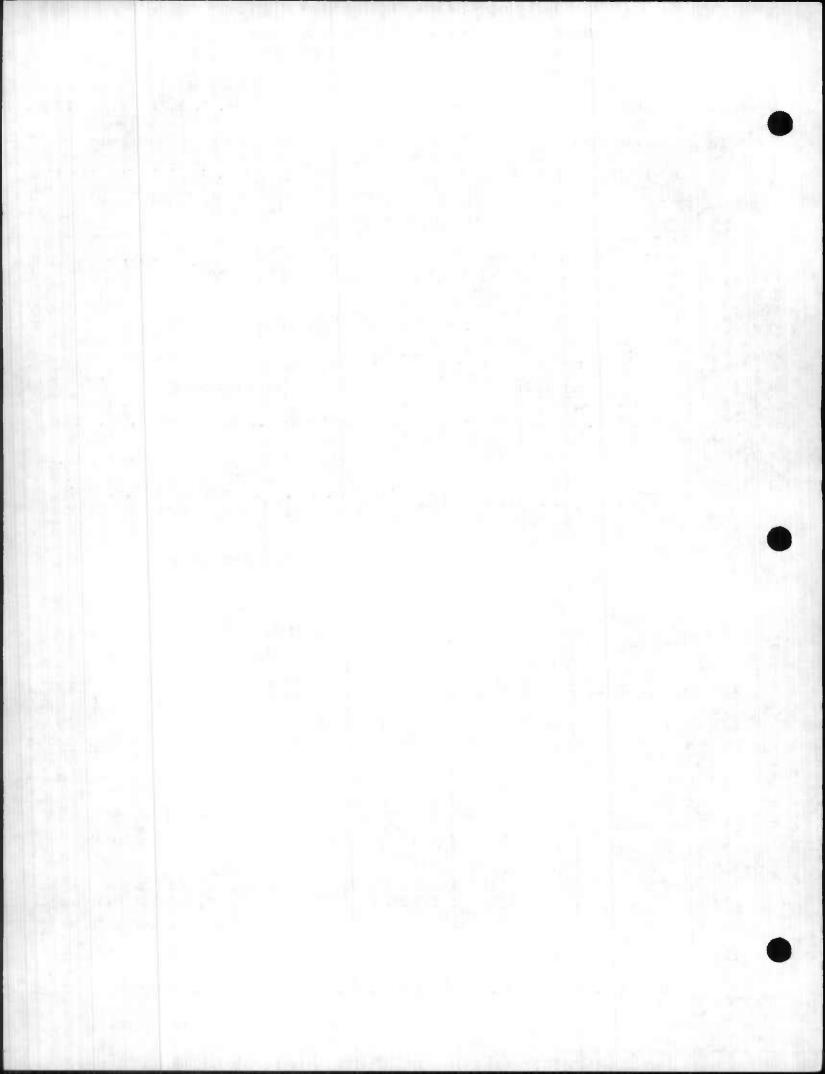


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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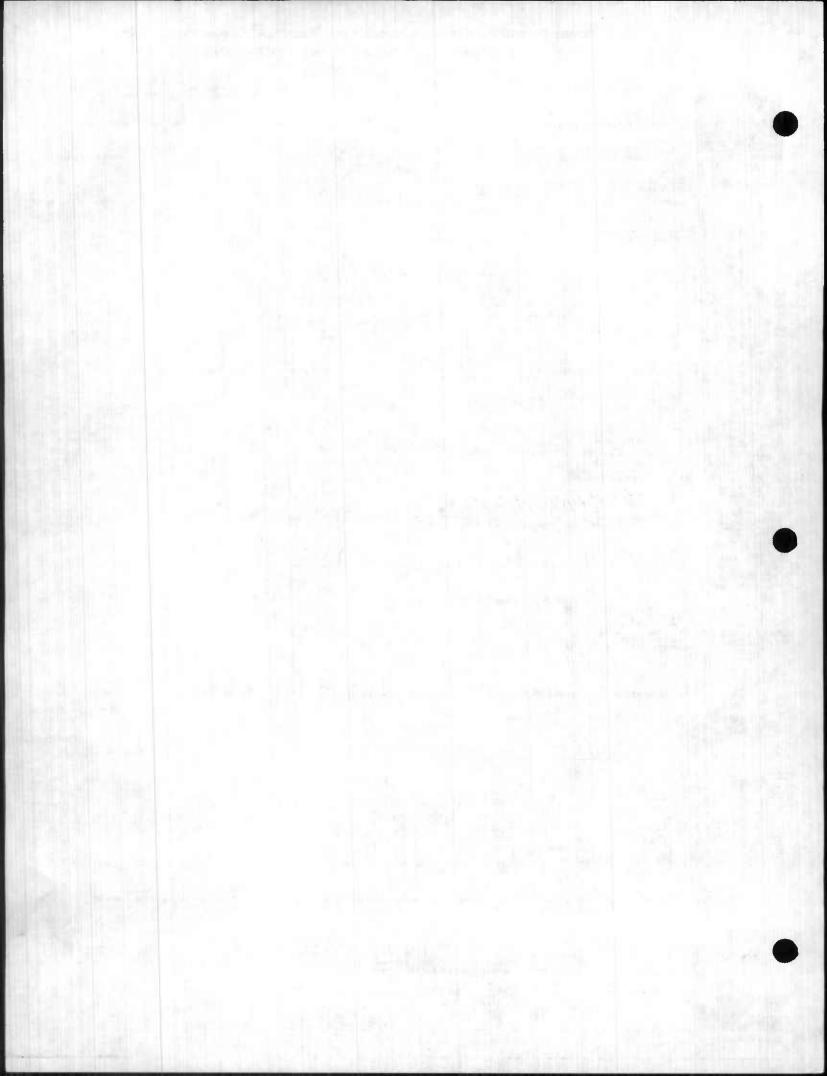
						Ceru	ilcale of	Dealli		Reg. No.		
	Physician /Medical	1. Decedent's Name (Fir Ruth E		oney C	ipione				2. Date of D Month Oct. 1	Dav	Year	3. Time of Deeth 6:15 PM.
	Examiner	4a Facility Name (If not	Institution, give st	reet end number)		1		4b. City, Town, o	Location of Dee	th 4c. County	of Death	
		Bedford C	Court					Silver	Spring	Mont	tgome	ery
-	Funeral	5. Social Security Number			(In yrs. last bit		If Under 1 Year					elece (Stete or Foreign
1	Director	579-22-5767	, 10	M 20XF 8	4	Yrs.	workins Days	riours wir	Oct. 1	2, 1915	West	Virginia
	9	Usual Residence of Deci										
	tel Let	10a. State 10b	. County		10c. City, Tow	m or Local	tion				1	Od. Inside City Limits
	o Me	Maryland M	lontgome	ry	Sil	Lver	Spring					1 ☐ Yes 2 No
	or 28a-f	10e. Street and Number					10f. Zip Code			10g. Citizen of V	/hat Cour	ntry?
	W 6 M	3701 Inter	national	Drive			2090	06		U.S	5.A.	
	her death with the Marys Herms 23s or 28s-f sho kner must be notified at Kuneral Director	11. Merital Status	12	2. Was Decedent E Armed Forces?	ver in U,S.	13. Wa	s Decedent of	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or N	o- 14. Raci	- Americ	can Indien,
0	岩 大百 4	1 Never Married	2 Married	1 Yes 2 No	0				nto rucain, etc.,			
Maryland 21215-0020	D E. C	3 ₺ Widowed 4 □	Divorced	Year or Detes:		1	]Yes 2∏ No	Specify.		Specify	Whi	lte
5	ad within 72 ho ygene. wer than "naturn it, the Medical. Completed		Decedent'a Educa		16e	. Deceden	nt's Usual Occu	pation duning most of w	orkina	16b. Kind of Bu	siness/In	duatry
21	un ign	Elementery/Secondery		College (1-4or 5-	-)	life. DO	NOT use retir	during most of w				
2	Son Base	12			Nu	ırsin	g Assis			Medica		
Pu		17. Father's Name (First,	Middle, Last)					18. Mother's Na	ame (First, Middle	e, Maiden Sumem	Θ)	
yla	Mental Harbard of Mental Harbard of Mental Harbard of To Be	Clayton H	larrison	Money			34	Eliza	Wright			
lar	the same	19a. Informant's Name/F	Reletionship (Typ	e, Print)				et end Number or I				
100	Health a	Christine A	. Cox -	Daughter	12	2755	Turquo	ise Terr.	, Silve	r Spring	, Md.	20904
ore	型 英 華	20e. Method of Disposition			20b. Place of cemeter	of Disposition, creme	ion (Neme of tory or other pl	ece)	Date	20c. Location -	City or To	own, State
Ĕ	Page ment m	1 Burial 2 1 Cre 4 Donation 5 D		movai from State	Natio	na1	Cremato	ory 10/5	/2000	Falls Cl	nurch	ı, Va.
Baltimore	Series and Series	21. Signature of Funeral	Service Licenses	•		22. N	lame end Add	ress of Facility $J_0$	seph Ga	wler's So	ons,	Inc.
m	22118	1-1	5	2. 0	· B.	5130	O Wisc.	Ave. NW	., Washi	Ington, I	. C.	20016
		23a. Pert1. Enter the dis	seese, or complic	ations that caused to	he deeth. Do	not enter	the mode of dy	ring, such as cardi	ec or respiretory	arrest,		Approximete Interval Between
	Medical Examiner Examiner Examiner	Immediate Cause (Final diseese or condition resulting in death)	a.		ma of d			dder With	Metast	isis	1	
	certificate be executed nding physician and use as the bunist-transit n/Medical Examir	Sequentially list condition	nce of):									
0,	be exe ician a burial-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events  Due to (or as a consequence of):  c						Managara - Land				
68760,	certificate be nding physicia use as the burn n/Medical	that initieted events resulting in death) Last	ue to (or es e consequence of):									
9	ding physics as the	South County Last										
30×			d.									
). B	ires that the death signed by the atte d be detached for d by Physicia	Part II. Other significant	conditions contr	ibuting to death but	not resulting I	n the unde	erlying cause g	iven in Pert i.	23b. Did	tobacco uae cor	tribute t	o the cause of death?
P.0	ed by the detached	153							10	Yee 2 No	3 Pro	bably 4 Unknown
	= 60							-	-			
Records,	been sign should be									s an autopsy formed?	av	ere eutopsy findings alleble prior to
S	law requires been 2 should										of	ompletion of cause death?
R	0 5 5								10	Yes 2X No	11	☐ Yes 2☐ No
Vital	certificate rector, pag	25. Wes case referred to	medical					26 Place of D	eath (Check only	one)		
>	Physician: this certific ral director.	examiner?		spital:	t 2 ER/O	utpatient	3 DOA O			sidence 6 Oth	er (Speci	(v)
ō	or this eral di	27. Manner of Death		28a. Date of Injury (Month, Dey		Time of	28c. Inj		7	how injury occur		77
Division	or Attending Fafter death. Director: After in by the funer	1 Maturel 5 [ 2 ☐ Accident	Pending Investigation	(Month, Dey	rear)	Injury		ork≀ ☐ Yes 2 ☐ No				
15	or Attendiate death. Director: A in by the fertificati	3 ☐ Suicide 6	Could not be determined	28e. Place of Injur	y - At home, fa	arm, atree	t, factory, office	•		(Street end Numb	er or Run	el Route Number,
Ö	tal or Attending P rs after death. al Director: After t led in by the funera Certification:	4 Homicide		building, efc.	(Specify)				City of 1	own, Stete)		
	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.  Medical Certification: To Be (			cian: To the best of er: On the basis of and manner stat	examination an							
	Within outh	29b. Signeture end title	of certifier		0	7. 3	29c. Licer	nse number		29d. Date signe	d (Month,	Day, Year)
		· M-	011	4.	*	na r	) 200	505		Oot E	2000	
	10	20 Name and address	west	Jurio	nth (Mary 222)	(Tupo Pri		5585		Oct. 5,	2000	,
		30. Name and address o			V			771	D 0	20006	E / O 7	
	0	Gilbert E. 31. Dete filed (Month, Da		Z, MD.,		ye St		Washing	on, D.C	. 20006-	540/	
	State Registrar	OCT	0 6 200			9.	Spork	2.				



# Please Type or Print in Biack indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certificate		R	eg. No.		12/69
	Physician	Decedent's Name (First, Middle, Las	(t)			2. Date of Deat Month	h Day	Year	3. Time of Death
	/Medical Examiner	James Waldo Churc  4a Facility Neme (If not institution, give			4b. City, Town, or Le	Septemocation of Death	oer 29,	2000 of Death	9:04 am
		Holy Cross Hospit	a1		Silver Sp	ring	Mont	gomer	v
	Funeral Director	5. Sociel Security Number 6. Se		last birthday) If Under 1 Y Yrs. Months D		8. Dete of Birth (Month, Day, Dec 1,	Year)		ace (State or Foreign
3		Usuel Residence of Decedent	100 00	y. Town or Location			,		
- Inches	adat or								od. Inside City Limits  1 ☐ Yes 2 ☐ No
1	or 28a-f shi be notified a	Maryland Montgome  10a. Street and Number	ry Whea	10f. Zip Co	de	1	0g. Citizen of V	Vhat Count	try?
7	2A O	2115 Arcola Avenu	e	20902		ı	JSA		
ar das	iber must iber must Funeral	11. Maritel Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Decedent If Yes, specify	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		a - America k, White, e	
To house after	by Exe	1 Never Married 21 Merried 3 Widowed 4 Divorced	1 ☑ Yes 2 ☐ No If Yes, Give 194 Year or Detes: 194	2- 1□ Yes 2⊠	No Specify:	412	Specify	Wh	ite
2 should be flad willin 72 hours at	ygene. er the Medical t, the Medical	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Decedent's Usual O (Give kind of work d life. DO NOT use re	ccupation one during most of work stired)	king	U.S. D		ment of
1	the A	Elementery/Secondary (0-12)	College (1-4or 5+) 5+	Naval Arche			the Na		
1 1	B seem	17. Father's Neme (First, Middle, Last)			18. Mother's Nam	e (First, Middle, I	Maiden Suman	10)	
-	J Men marks marks To	Guy Irving Church	Service (Carlot)	19b. Meiling Address (SI	Olive C1			State 7in	Codel
0 10	O ST	19a. Informant's Name/Relationship (1) Mary Kelleher Chu		2115 Arcola			20902	State, Zip	C006)
	If Head	20a. Method of Disposition	20b. F	Place of Disposition (Name of the state of t	f		20c. Location -	City or To	wn, Stete
Panes	ant: #	1 Depurial 2 Cremation 3 4 Donation 5 Other (Specify	Hemoval from State	e of Heaven		0/3/00 8	Silver	Sprin	g, MD
- Committee	Depart Import any inj	21. Signature of Funeral Service Licen	500 4 . Ang 110 a	Francis	ddress of Facility J. Collins versity Blv				
d	hysician /Medical ixaminer	23a Part 1. Enter the disease, or compensations, or heart failure. List only of the compensation in the compensation resulting in deeth)	. Cona	estive lifes a consequence of):	dying, such as cardiac	or respiratory err	est.	e	Approximete Interval Between Onset and Death
death cadificate be executed		Cause (Disease or Injury that initiated events resulting in death) Last	C	r as a consequence of):	Parro				
Head	0 % 40	Pert il. Other significant conditions co	ontributing to death but not res	ulting in the underlying caus	e given in Part I.	23b. Did to	obacco use co	ntribute to	the cause of death?
the the	80					1 🗆 Y	es 2 No	3 Prot	bebly 4 Unknown
or Attending Division. The law requires	2 should					24a. Wes e		ava	ere autopsy findings allable prior to appletion of cause death?
The	page page					1 🗆 Y	es 2/2/No	10	Yes 2□ No
- Call	certificate rector, pa	25. Was case referred to medical examiner?	Hospital:	/		th (Check only or	70)		
Physician.	電点 上	1 ☐ Yes 2 ☐ No 27. Manner of Deeth	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ DOA 28b. Time of 28c.		ome 5 Residence 128d. Describe h			()
Attending	death. ctor: After y the funer fication:	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury M	Injury et Work? 1 Yes 2 No				
Lor Am	rs after death. al Director: After ted in by the funers Certification:	3 Suicide 6 Could not be determined	28e. Placa of Injury - At he building, etc. (Specif	ome, farm, street, factory, of	fice	28f. Location (S City or Town		oer or Rura	l Route Number,
anita	in the	29a. Certifier 1 Certifying Phy (Check only 2 Medical Example)	/alcian: To the best of my kno liner: On the besis of examina miner stated.	wledge, deeth occurred et ti tion and/or investigation, in	ne time, dete and plece, my opinion, death occur	, end due to the c rred at the time, d	ause(s) and mi ate and pleca,	anner as st and due to	ated. the cause(s)
Toth	within 24 To the Fu completel	29b. Signature and title at confirm	11/		cense number		9d. Date signe		
	10+1	1/8/16	1	13 Geors	0365		Septe	mbe	30,2000
	1-11	30. Name and address of purson who	completed cause of death (Item	n 23a) (Type, Print)	10. Aug H	308 0	Juge S	000	Mel ango
	State	PETER J. SAB 31. Date filed (Month, Day, Year)	32. Røgistrar's Signa	ature /	1700	200 3	11081 3	BEING	1114 2010
	State	A 4 4 4 A	000						

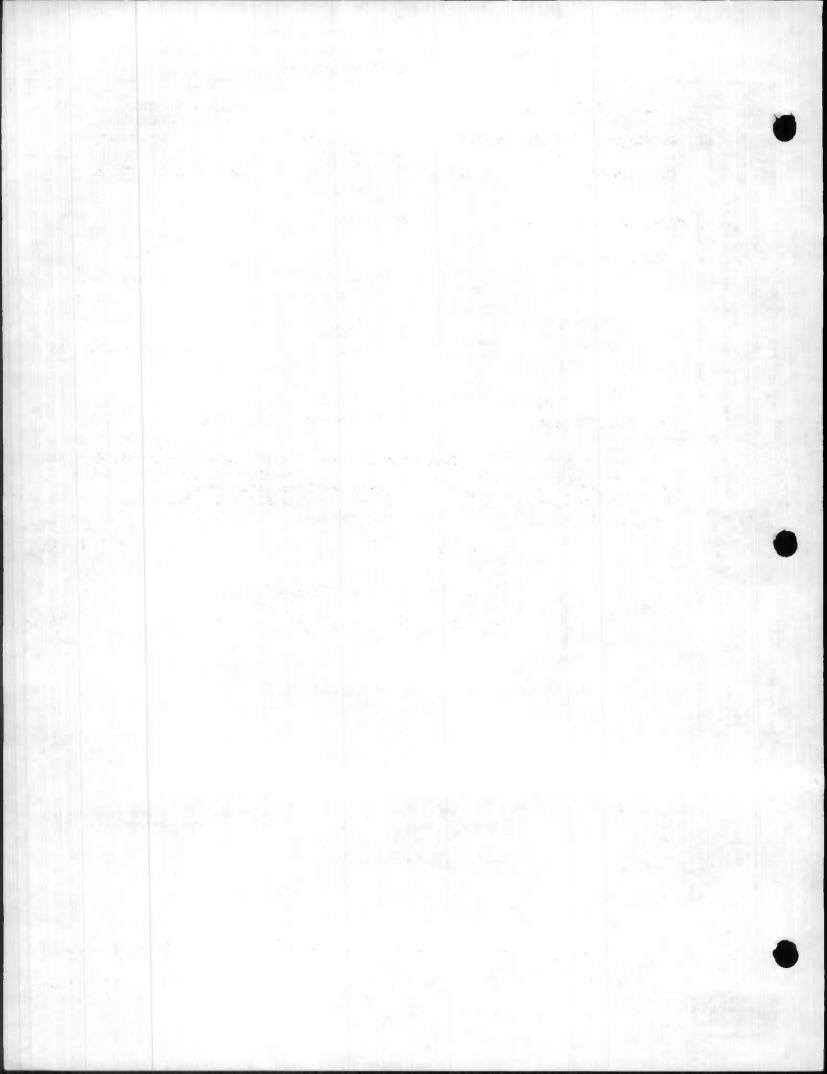
Registrar



State of Maryland / Department of Health and Mental Hygiene 00

				Ce	rtificate of	Death		Reg. No.	0	06/10	
		1. Decedent's Name (First, Middla, L	ast)				2. Date of De Month		Yaer	3. Time of Death	
	Physician / Medical	Yue Fook	Chui					r 2, 200		5:48 PM	
	Examiner	4a Fecility Nama (If not institution, g	ive street and number)			4b. City, Town, or	Location of Death	4c. County	of Death		
		Washington Adver	ntist Hospital			Takoma P	ark	Mont	gomei	cy	
	Funeral Director	097-72-9595	Sex 1	s. last birthday) Yrs.	If Under 1 Year Months Days			y, Yaar) 1927	9. Birthi Cou Chin	place (Stata or Foraign intry)	
	and *	Usual Rasidance of Decedant  10e. State 10b. County	10c. C	ity. Town or Lo	ocation				Т.	10d. Inside City Limits	
	l sho	Wanniand Manta		Cilvor	Spring					1 ☐ Yes 2√2 No	
	the N	Maryland Montgo	omery	DITAGE	10f. Zip Coda			10g. Citizen of V	What Cou	ntry?	
	death with the Meryland rms 23s or 28s-f show rms 15s or 28s-f show rms 15s or 28s-f show rms 25s or 28s-f show rms 25s or 28s-f show		,		2090	1/4		Chi			
	ne 23	1200 Canyon Road	12. Was Decedent Ever in	U.S. 13.			Specify Yas or No			can Indian,	
21215-0020	or its	1 ☐ Nevar Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forcas?		If Yas, specify Cut 1□ Yas 2⊠ No	Hispanic Origin? ( ban, Maxicen, Pua Specify:	rto Ricen, atc.)	Specify	ck, Whita,	sian	
2-0	should be filed within 72 hours nd Mentel Hygiene. merked other than "natural, matic event, the Medical Exi-	15. Decedant's I	Education rade complated)	16a. Dace	dant's Usual Occu	pation a during most of w	orkina	16b. Kind of Bi	usiness/In	dustry	
21	within one.	Elementary/Secondary (0-12)	College (1-4or 5+)	lifa.		during most of weed)		Morcha	nt Si	hipping	
	Hygier then the ent, the	6			Sailor	T				Tipping	
Maryland	d out	17. Father's Nama (First, Middle, Las	60)				ama (First, Middle,	Maidan Suman	na)		
N/S	should and Men marke umarke	Sun Chui				Mui Yu					
la	2 sh end is m	19a. Informant's Name/Ralationship				et and Number or F				- 1	
	end m 27 her tr	Annie Yeh / Daug				Road, Sil			209		
Baltimore,	permit. Pages 1 end 2 should be filed within Department of Health end Mentel Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Managada.  To Be Completed the complete of the Managada.	20a. Mathod of Disposition  1 Buriai 2 Dramation 3  4 Donation 5 Other (Special Content of the C	Ramoval from Stata	rt Line		natory 10			od,	Maryland	
Balt	permit. Departr Importa any inju	21. Signature of Paneral Service Lio	71/J/J		11800 Nev	w Hampship pring, Ma	ire Avenu		eral	Home	
		23a. Part1. Enter tha diseasa, or con shock, or haart failura. List on	mplications that caused the dec						1	Approximate Interval Batween	
	Physician /Medical Examiner	Immediata Causa (Final disaasa or condition	Septi	c	Shoc	K				Onsat and Death	
2	ē interes	rasulting in daath)	Sever	(or as a consec	quence of):	topen	ia		. 1	3 month	
Box 68760,	certificate be executed ding physician end use es the bunel-transit and AMedical Examiner										
. 8	deeth ce e ettendi d for use	Part II. Other eignificant conditions	contributing to death but not re	sulting In the u	ndariving causa g	ivan in Part I.	23b. Dld	tobacco usa co	ntribute t	to the cause of death?	
P.0	that the deeth ce ed by the ettendi deteched for use Physician/I				, and the second			Yes 2 No		obably 4 Unknown	
Records,	The law requires that the deeth oe sate has been signed by the ettendi, page 2 should be deteched for use Completed by Physician/						24a. Was perfo	an autopsy ormed?	a\ cc	Vara autopsy findings vailable prior to ompletion of cause f death?	
	The late he page						10	Yas 2 No	1	☐ Yas 2☐ No	
ta	stelen: The law s certificate has to lirector, page 2 s o Be Compli	25. Was cesa rafarrad to medical axaminar?				26. Place of Da	aath (Chack only	one)			
>	hysica his ca al direc	1 Yas 2 No	Hospital: 1 Inpatient 2	ER/Outpaties	nt 3 DOA	thar: 4 Nursing	Home 5 ☐ Rasi	dance 6 Oth	ar (Speci	(fy)	
Division of Vital	Attending Physician: or death. ector: After this certific by the funeral director, iffication: To Be (	27. Mannar of Death  1 Natural 5 Panding 2 Accident Invastigati	28a. Data of Injury (Month, Day Year)	28b. Tima o Injury	W	ury at ork? ] Yas 2   No	28d. Describe	how injury occur	rad		
Divis	tal or Attending P rs efter death. al Director: After t led in by the funera Certification:	3 ☐ Suicida 6 ☐ Could not 4 ☐ Homloida datermine			raat, factory, office		28f. Location ( City or To	Streat and Numb wn, Stata)	per or Rur	rai Route Number,	
	To the Hospital or Attending Physicien: The I within 24 hours efter death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page  Medical Certification: To Be Com		hysician: To the best of my kniminer: Of the basis of examin								
	To the somp	29b. Signature and the of certifier	1		29c. Licer	nse number		29d. Data signa	d (Month,	Day, Year)	
	5	Mal	Man	MID	Deint)	4182	8	Octo	rey	2,2000	
		30. Name and addrass of person who	complated cause of death (Ite	1801	Jeorgia	a Ave =	#337 S	ilversy	ring	MD 20902	
	State Registrar	31. Date filed (Month, Day, Yaar) OCT 0 5 2	32 Ragistrar's Sign	B.	poiss	1					

DHMH 16 Rev 6/95



#### Please

Please Type or Print	in Black Indelible Ink. Assure	All Copies Are Legible.	
State of Mai	yland / Department of Health and	Mental Hygiene	3277
	Certificate of Death	Reg. No.	
Decedent's Neme (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of De

/Medical		Daisy Oretta	Campbe			Octobe		000 10:30 A.M.					
- Examiner	4e Fecility Neme (If not institution, giv	e street end number)		1000	4b. City, Town, o	r Location of Deet	h 4c. County	of Death					
	3516 Hargo Stree	et			Wheaton			gomery					
Funeral	5. Social Security Number 6. S	C		Months Days	If Under 24 Hi		rth ay, Year)	Birthplace (State or Foreign Country)					
Director	230-30-1333	85 85	Yrs.			Septemb	er 13,1915	West Virginia					
7 .	Usual Residence of Decedent	140-04	Town bullet	-47				land to the On Allen					
at day	10a. State 10b. County		, Town or Loc	ation				10d. Inside City Limits 1 ☐ Yes 2 No					
oto me w	Maryland Montgom	ery Wh	eaton					T Tes 220 No					
or 28a-fa be notified Directo	10a. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?					
	3516 Hargo Stre	et		2090	6	March 1990	United	States					
har death v r heme 23s siner munt Furneral	11. Marital Status	12. Was Decedent Ever in U,S Armed Forces?	S. 13. W	es Decedent of H	Hispanic Origin?	(Specify Yes or No erto Rican, etc.)	0- 14. Rac	e - American Indian, sk, White, etc.					
	1 Never Married 2 Married	1 ☐ Yes 2 🖾 No		Yes 2 No		Bito Hibari, Sto.,		F.73					
Eran Dy	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		LITES ZELINO	Specify.		Specify	white					
ad with 72 ho hygiene, wr then *nature vt, the Medical.	15. Decedent's Ed		16a. Decede	ent's Usual Occup	pation	ndina	16b. Kind of Bu	usiness/Industry					
Mad ald	(Specify only highest gra	College (1-4or 5+)	life. D	ind of work done O NOT use retire	d)	rotking	100						
the state of	12		H	omemaker			Own	Home					
d De lie mini Hy and other c event,	17. Father's Name (First, Middle, Last)		31.4.4		18. Mother's N	ame (First, Middle	, Maiden Surnam	16)					
for the second of the second o	Francis Logan	Spencer			Virgi	nia Bail	.es						
S S S S S S S S S S S S S S S S S S S	19a. Informent's Name/Relationship (	Type, Print)	19b. Mailing	Address (Street	and Number or	Rurel Route Numb	per, City or Town,	State, Zip Code)					
Man and and and and and and and and and a	James Michael Cam	pbell/Son	19048	Steeple	Place,	Germanto	own, Mar	yland 20874					
Umore, Pages 1 a ment of Hear Water of Other Office of the Other of Other Office of the Other office of th	20a. Method of Disposition	20b. Pl	lace of Dispos	ition (Name of etory or other pla	001	Date	20c. Location -	City or Town, State					
O SOLL P	1 X Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	JHemovel from State		apel Ceme		October 7, 2000	Nottio	West Virginia					
of the last	21 Signature of Fusieral Service Lices			-	-								
D some	Will B.	1008 MO08	46 Rot	pert A. Pu 7 Wiscons	in Avenue	meral Home , Bethesda	e/Bethesda , Maryland	-Chevy Chase, Inc. d 20814-3501					
	23a. Part . Enter the disease, or com shock, or heart failure. List only	plications that caused the death	n. Do not ente	r the mode of dyi	ng, such as card	iac or respiretory	arrest,	Approximate					
Physician	anops, or heart railure. List only	one base on each line.						Interval Between Onset end Deeth					
/Medical	Immediate Ceuse (Finel	Gastro-Inte	11	TY 1-				2 D					
Examiner	disease or condition resulting in deeth)	3 Days											
<u> </u>		Gastritis	r as a consequ	ienca oi).				10 Days					
uted ansit		10 Days											
be executed sician and burial-transit	if any, leading to immediate												
the death certificate be executed by the attending physician and iched for use as the burial-transit sysician/Medical Examiner	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events												
certificate ding phys is a as the	tresulting in death) Last  Due to (or as a consequence of):												
ath certificate be attending physician for use as the bunisham/Medical E	d												
daath daath e atten		ntribute to the cause of death?											
y the sched	Part II. Other significant conditions of	ontributing to death but not resu	utting in the un	derlying cause gr	ven in Part I.								
P dete						1	) Yes 210 No	3 Probably 4 Unknown					
necolds, release that she she she she she signed to ge 2 should be det						24a Was	s an autopsy	24b. Were autopsy findings					
The law require tage 2 should to Completed						perl	ormed?	eveilable prior to completion of cause					
law nes b e 2 s mpi								of death?					
- = = = 0						10	Yes 2 No	1 ☐ Yes 2 ☐ No					
ysician: The law ysician: The law is certificate hes i director, page 2 i	25. Was case referred to medical examiner?					Death (Check only	one)						
Physician: this certific ral director,	1 No 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 DOA	her: 4 Nursing	Home 5 N Res	idenca 6 □Oth	er (Specify)					
tanding Physical Collection: To Ication: T	27. Menner of Death 1 Natural 5 ☐ Pending	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	ry et rk?	28d. Describe	how injury occur	red					
Attending in death.  Actor: After by the fund iffication	2 Accident investigation				Yes 2 No								
tal or Attanding P rs after death. al Director: After ted in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Plece of Injury - At ho building, etc. (Specify	ome, farm, stre	et, factory, office		28f. Location City or To	(Street end Numb own, State)	per or Rural Route Number,					
Sed in Cert													
		nysician: To the best of my knowniner: On the basis of examinat											
he Hosp in 24 hou he Funer pletaly fil	one)	and manner steted.	ron and/or my			Journal of the third							
To the trop with	29b. Signature and title of certifier	1091	soil.	29c. Licens				d (Month, Day, Year)					
5	Mucho	Dr. John	W M	DO	1138		Uctober	2, 2000					
	30. Name and eddress of person who	completed cause of deeth (Item	23a) (Type, F	Print)				20906					

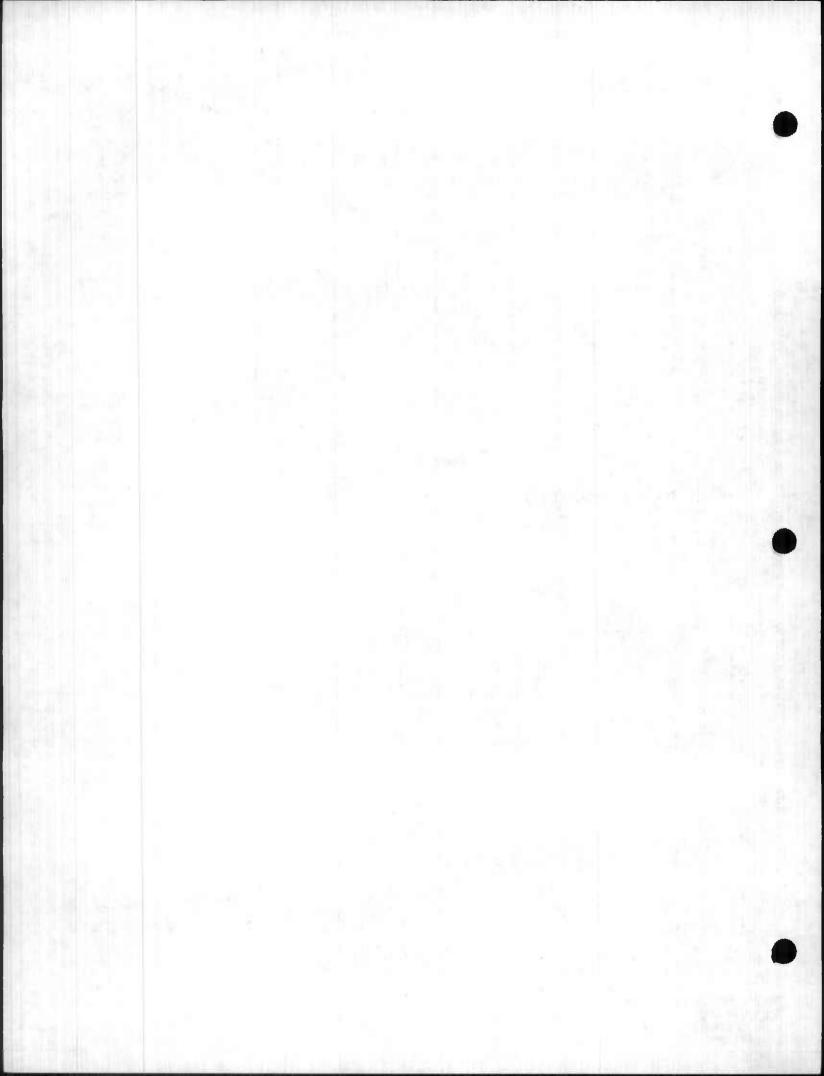
DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year)
OCT 6 3

32. Registrar's Signature

Michael R. Dobridge, M.D., 13975 Connecticut Avenue #308, Silver Spring, Maryland



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible		Please	Туре	or	<b>Print</b>	in	Black	Indelible	lnk.	Assure	All	Copies	Are	Legi	ble
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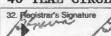
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician OCTOBER 02, 2000 8:24 P.M. Martha Campbell /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Berlin Nursing & Rehabilitation Center Berlin Worcester If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs 5. Social Security Number 6. Sex 8. Dete of Birth (Month, Dev. Year) Birthplece (State or Foreign Country) **Funeral** Hours Months Days 1□ M 2⊠ F 94 Director 264-24-8085 Dec. 25, 1905 South Carolina Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other then "natural", or hams 23s or 28s-f show troumstic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☒ No Director Maryland Worcester Whaleysville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? is 1 and 2 should be filed within 72 hours effer death wif Health and Mental Hygiene. If the marked other then "natural", or thems 23a. 11101 Hall Road USA 21872 Funeral 14. Raca - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: à 3 N Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4th grade laborer Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) unknown Alice Abraham 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 11101 Hall Road - Whaleysville, MD 21872 Albert Hilliard, Sr./nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, cremetory or other place) 20c. Location - City or Town, State Pages nent or 1 D'Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) St. Paul UM Ch. Cemetery 10/07/00 Berlin, Maryland 21 Signature of Funeral Service Licen 22. Name end Address of Fecility 1213 Jersey Road - Salisbury, MD JOLLEY MEMORIAL CHAPEL 21801 that counsed the death. Do not enter the mode of dying, such as cardiac or respiretory errest, ichuse on each ire. Approximete Intervel Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examine Examiner 20206 2 attending physicien end for use es the burlal-trensit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 ☐ Yes 2X No 1 ☐ Yes 2X No certificata 25. Was case referred to medicat examiner? 8 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. tnjury et Work? 5 Pending investigation or Attending 1 Natural s after death.
I Director: After od in by the fur 1 TYes 2 No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) To the Hospital or A within 24 hours after To the Funerel Directompletely filled in by 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date end placa, end due to the ceuse(s) and menner as stated.

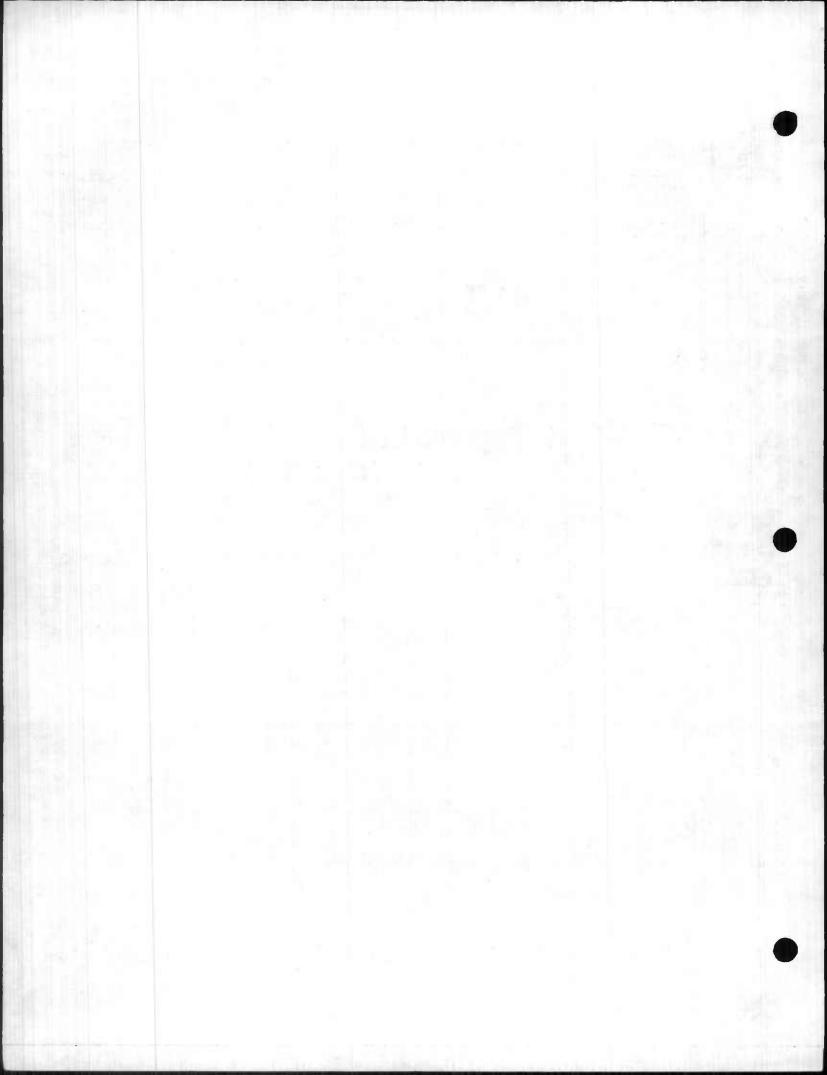
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of condi-29c. License number 29d. Date signed (Month, Day, Year) D02026 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 46 TEAL CIRCLE, BERLIN, MD DR. FEDERICO ARTHES, 31. Date filed (Month, Day, Year)

State Registrar

OCT 04 2000

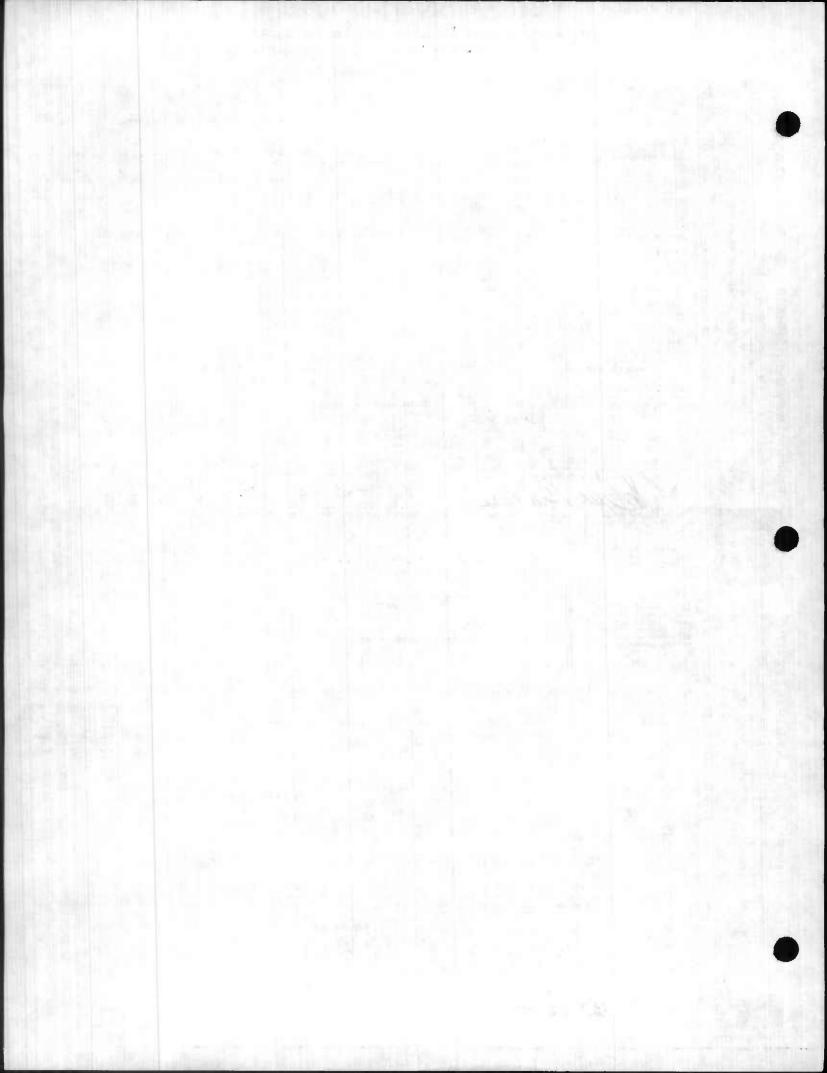


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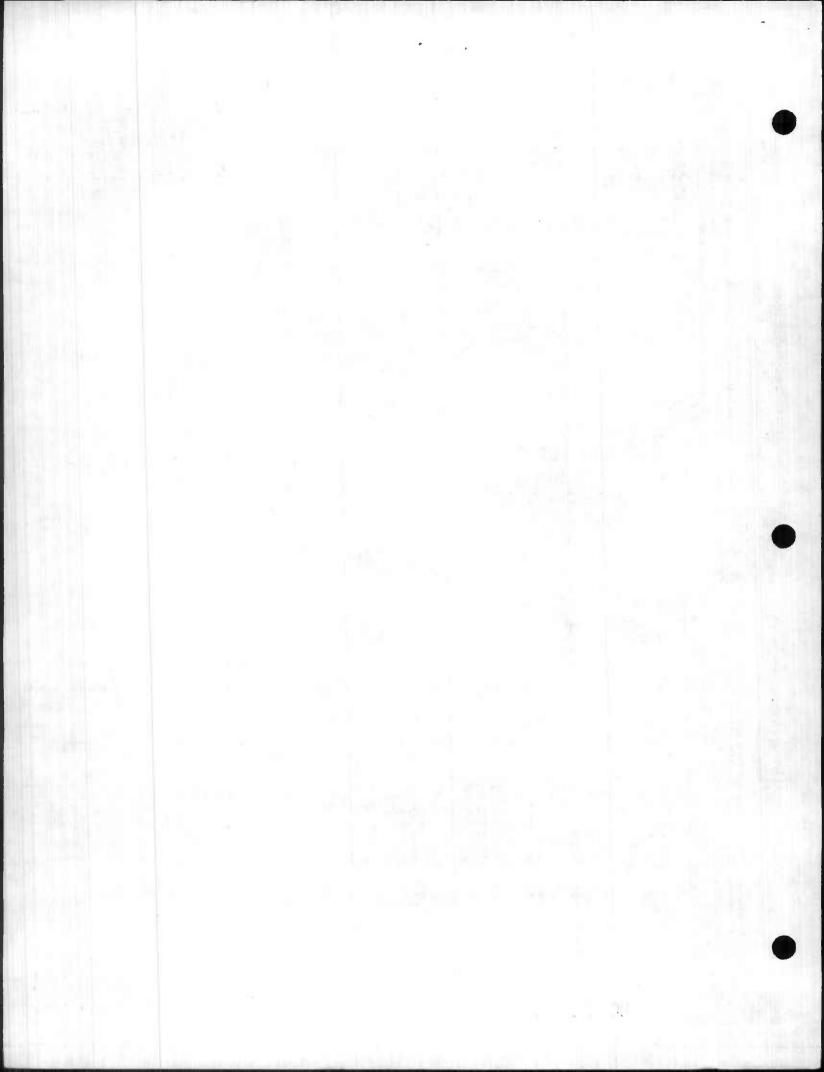


State of Maryland / Department of Health and Mental Hygiene 00 32773

Usual Rasidence of Decedent 10a. Stata 10b. County  Morceste 10e. Street and Number 10e. Street and Number 11. Merital Status 1 Never Married 2 Married 12 Widowed 4 Divorced 15. Decedent's Ed (Specify only highast grant Elamantary/Secondary (0-12) 11 17. Fathar's Nama (First, Middle, Last) Peter Lubic 19a. Informant's Name/Ralationship (1) (Cathleen Deimler — 20a. Mathod of Disposition 1 M Burial 2 Cremation 3 — 4 Donetton 5 Other (Specify 21. Signature of Fueral Service Licen 23a. Part. Enter the disease of companion, or heart failure. List only information of the state	Armed Forcas?  1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yrs.  Yrs.  Place of Disposematary, crak  Yrs.  16a. Dece (Give lifta).  19b. Mailit 1210  Place of Disposematary crak  Hill	Months Da  Docation  ty  101. Zip Coc  21  Was Decedant ff Yes, specify to kind of work de DO NOT usa re  ewife  ing Addrass (St.  7 A. A.  Dosition (Nama of matory or other  Cemete 2. Nama end Ad	Berlin ear Hundar 24 ays Hours A  da  842 of Hispanic Origin Cuben, Maxican, P No Specify: coupation ona during most of stired)  18. Mothar's Mary I reet and Number of ngler RD of place)	Min. 2/2/19  7 (Specify Yas or Nuarto Rican, atc.)  working  Neme (First, Middle Dessie Shar Rural Routa Num  Ocean C	Dey 2000  th 4c. County Worce  rth, Year) 21  10g. Citizan of V  USA  o- 14. Rac Blec  Specify  16b. Kind of Bi  Homema  a, Maidan Surnam  eaffer  ber, City or Town,	year 1 of Death ester 9. Birthplac Country PA  10d  Whet Country e- American ck, White, atc White usiness/Indus  ker na)  Stata, Zip Co. 2184 City or Towr	indien, c. stry						
Atlantic General  Atlantic General  S. Social Security Number  CO4-03-9182  Usual Rasidence of Decedent  10a. Stata  10b. County  MD  Worceste  10e. Street and Number  2107 A. Angler R  11. Merital Status  1 Never Married 2 Married  Widowed 4 Divorced  15. Decedent's Ed  (Specify only highast grave  Elamantary/Secondary (0-12)  11  17. Fathar's Nama (First, Middle, Last)  Peter Lubic  19a. Informant's Name/Ratationship (1)  (Athleen Deimler —  20a. Mathod of Disposition  1 M Burial 2 Cremation 3 —  4 Donetlon 5 Other (Specify  21. Signature of Fueral Service Licen  23a. Part. Enter the disease of companion, or heart failure. List only information.	a street and number)  Hospital  AX 7. Aga (In yrs. 79)  10c. Ci  CY OC  112. Wes Decedent Evar in U Armed Forcas? 1 yes X No H Yas, Gwa Yeer or Datas:  Sucation Ida complatad)  Collega (1-4 or 5+)  Type, Print)  Niece  Cal	Yrs.  Yrs.  Place of Disposematary, crak  Yrs.  16a. Dece (Give lifta).  19b. Mailit 1210  Place of Disposematary crak  Hill	Months Da coation  ty  10f. Zip Coc  21  Was Decedant ff Yes, specify ( 1	Berlin ear Hundar 24 ays Hours A  da  842 of Hispanic Origin Cuben, Maxican, P No Specify: coupation ona during most of stired)  18. Mothar's Mary I reet and Number of ngler RD of place)	9/28/ or Location of Dea  Hrs. 8. Data of B (Month, D 2/2/19  P. (Specify Yas or N uarto Rican, atc.)  working  Neme (First, Middli Dessie Sh or Rural Routa Num , Ocean C	2000 th 4c. County Worce irth ley, Year) 21  10g. Citizen of V USA 0- 14. Rac Blec Specify 16b. Kind of Bi Homema a, Maidan Suman eaffer ber, City or Town, ity, MD 20c. Location	9. Birthplac Country PA  10d  Whet Country	ce (Stata or Foraig ) I finaide City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						
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Atlantic General  5. Social Security Number  6. St. 204-03-9182  Usual Rasidence of Decedent  10a. Stata  10b. County  MD  Worceste  10e. Street and Number  2107 A. Angler R  11. Merital Status  1 Never Married 2 Married  (Specify only highast grave)  Elamantary/Secondary (0-12)  11  17. Fathar's Nama (First, Middle, Last)  Peter Lubic  19a. Informant's Name/Ratationship (1)  (Athleen Deimler —  20a. Mathod of Disposition  1 M Burial 2 Cremation 3 — 4 Donetlon 5 Other (Specify  21. Signature of Fundal Service Licen  23a. Part. Enter the disease of companion, or heart failure. List only immediate Causa (Final	Hospital  A Aga (In yrs. 79  10c. Ci  C C  112. Wes Decedent Evar in U Armed Forcas? 1   Yes   Yes No If Yas, Gwa Yeer or Datas:  Sucation Ida complatad)  Collega (1-4or 5+)  Type, Print)  Niece  Cal	Yrs.  Yrs.  ean Ci  J,S. 13.  16a. Dece (Give liffa).  HOUSe  19b. Mailit 1210  Place of Disposematary, cra  k Hill  The	Months Da coation  ty  10f. Zip Coc  21  Was Decedant ff Yes, specify ( 1	Berlin ear Hundar 24 ays Hours A  da  842 of Hispanic Origin Cuben, Maxican, P No Specify: coupation ona during most of stired)  18. Mothar's Mary I reet and Number of ngler RD of place)	R. Data of B. (Month, D. 2/2/19)  R. (Specify Yas or Nuarto Rican, atc.)  Working  Neme (First, Middli Dessie Sh. or Rural Routa Num., Ocean C. Data	Worce  irth ey, Year) 21  10g. Citizen of V  USA  0- 14. Rac Blet Specify  16b. Kind of Bi  Homema a, Maidan Suman eaffer ber, City or Town, ity, MD  20c. Location	9. Birthplac Country PA  10d  Whet Country e- American ck, White, atc White usinass/Indus ker na)  Stata, Zip Co 2184 City or Towr	. fneide City Limits 1 X Yas 2 No 17 Indien, stry						
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20a. Mathod of Disposition  1 M Burial 2 Cremation 3 Company of Principle Service Licental	JRamoval from Stata  V)  Oal	Place of Disposematary, cra  k Hill  2	osition (Nama o matory or other Cemete 2. Nama end Ad	of place)	Data	20c. Location	City or Town							
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Immediata Causa (Final disaasa or condition a. Acute Reum Fulure														
Immediata Causa (Final disease or condition														
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Cause (Disease or injury C. Va.Sull H.S														
triat initiated avants	Dua to (d	or as a conse	quance of):											
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Part II. Other significant conditions of	ontributing to death but not ras	sulting in the	undariving ceus	a given in Part I.	23b. Die	tobacco use co	ntribute to ti	he cause of deat						
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ALVII USULE						N. 154 - 15 - 11   15   15   15   15   15   15	1 04h Wass	a sudanas dia dinas						
					24a. Wa	s an autopsy formed?	evail	able prior to						
					_		of da	plation of cause ath?						
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25. Was casa referred to medicel examiner?	11			-	Daath (Chack only	ona)								
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	28e. Data of Injury		of 28c.	Injury at Work?	28d. Dascribe	how injury occur	rred							
1 Accident Investigation		пдагу		1 Yas 2 No										
3 ☐ Suicide 6 ☐ Could not be	e 28e. Place of thiury - At h	nome, ferm, st	treet, fectory, of	fice	28f. Location	(Street end Num	ber or Rural F	Routa Number,						
4 Homicida detarmined	building, atc. (Speci	ify)	,,, 0											
	29a. Cartifier 32 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, en													
Z MOUICEI CART	genon, i/i i	opinion, daam		, auto ena piece,	5,70 000 to II	00000(0)								
one)	niner: On the basis of axamina and manner stated.		29d. Data signe	ed (Month, De	y, Year)									
one)	niner: On the basis of examina		29c. Li	1 1 m 1 00										
one)	niner: On the basis of examina					00/	0/1	171.0						
29b. Signeture end title of certifier	niner: On the basis of examina and manner stated.		H	10653717	/	09/2	18/20	000						
29b. Signeture end titla of certifiar  90 30. Nama and and the series of person who describes the series of person who de	niner: On the basis of examina	m 23a) (Type	H		1	09/2	18/20	000						
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	25. Was casa referred to medicel examiner?  1 Yes 2 No  27. Mennar of Death 1 Neturel 5 Pending Investigation 3 Suicide 6 Could not be detarmined	Dua to (  25. Was casa referred to medical examiner?  1	Dua to (or as a conservation of the property o	Dua to (or as a consequence of):    A	Due to (or as a consequence of):    A	Dua to (or as a consequence of):  d.  Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.  23b. Did  24a. Wa per  25. Was case referred to medical examiner? 1   Yes 27   No	Due to (or as a consequence of):    A.	Dua to (or as a consequence of):    Continue to the significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.   Continue to the significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.   Continue to the significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.   Continue to the significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.   Continue to the significant conditions contribute to the significant conditions conditions contribute to the causal conditions c						



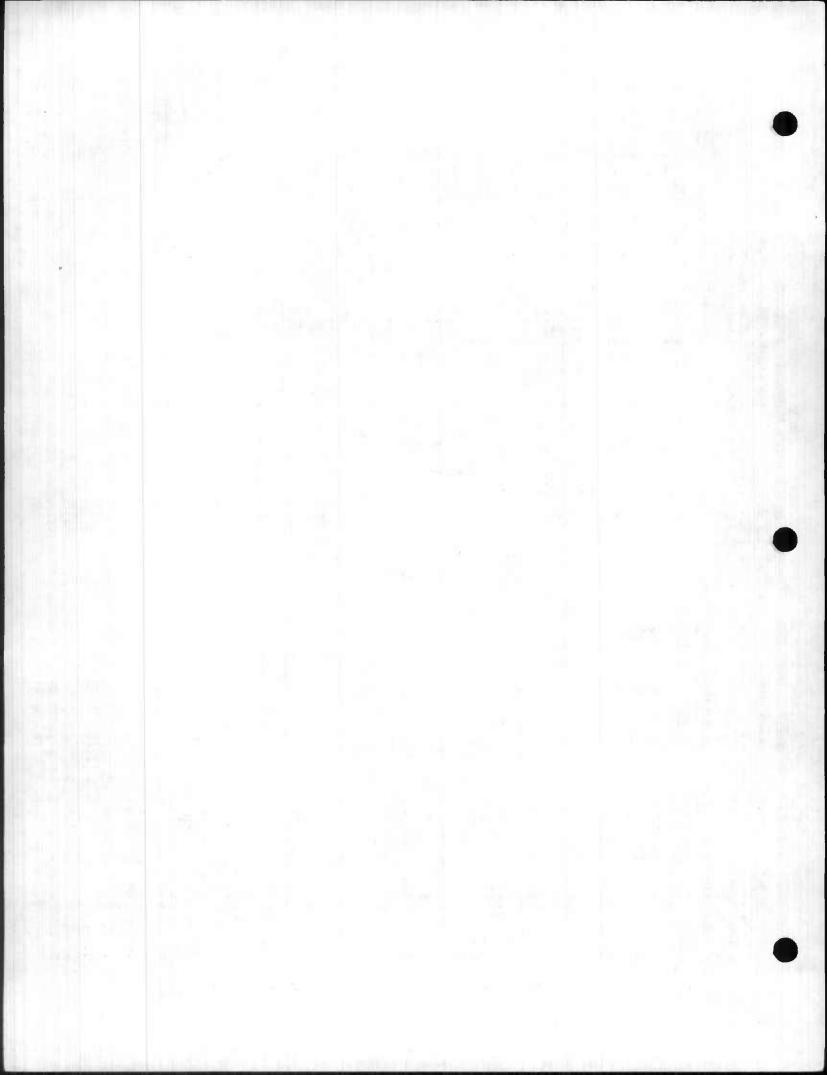
Piease Type or Print in Biack indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** arah 10:02 pin atherine 30 00 /Medical 4a Facility Name (If not Institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Worcester 6. Sex If Under 1 Year 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Months 262-1 M 2 F 46-5082 66 Yrs. Director Usual Residence of Decedent death with the Maryland 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28a-f show traumstic avent, the Wed call Examinar must be notified at 1 Yes 2 No Funeral Director cest 0 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 85 Wes Decedant Evar in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) Race - American Indian, Black, White, etc. or items 12. 11 Marital Status Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married I ☐ Yes 2 N If Yes, Give Yeer or Detes: 2 No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) LINE-WORKER Campball Soup If from 27 is marked other or other traumatic avent, is 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be 0 ames 19a. Informant's Neme/Relationship (Type, Print) 19d/Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 603 Second St aughter Pocomoke duno 20b. Place of Disposition (Neme of cemetery, crametory or other plecs) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 10 Burial 2 Cramation 3 Ramoval from Stata Department of Important: If any Injury or Donation 5 Other (Specify) Macedonia Memoria/PK Westover. 21. Signature of Funeral Service Licansee 22. Name end Address of Facility 23e. Fart1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as caldidad or respiratory arrest, shock, or heart failure. List only one cause on each line. 2185/ Approximate Interval Between Onset and Death Physician /Medical tmmediate Ceuse (Finel diseese or condition resulting in death) Examiner Examiner tha burial-transit Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequenca of): and or Attending Physician: The law requires that the death certificate be execu Box 68760. Physician/Medicai Due to (or as a consequenca of) for usa as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. been signed by the should be datached 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? paga 2 212 No 1 Yes 1 Yes 2□ No cartificata funeral director, Be 25. Wes case referred to medicat examiner? 26. Placa of Deeth (Check only one) Hospital: Other: 4 Nursing Home 2 No Medical Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) Aftar this 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Netural 1 Yes 2 No within 24 hours after death. To the Funeral Director: Al 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, date end place, end due to the cause(s) and manner es steted. 29a. Certifier completaly 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) end menner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) R 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State 1 0 2000 OCT Registrar



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State of Maryland / Department of Health and Mental Hygiene 3 2 7 7 5

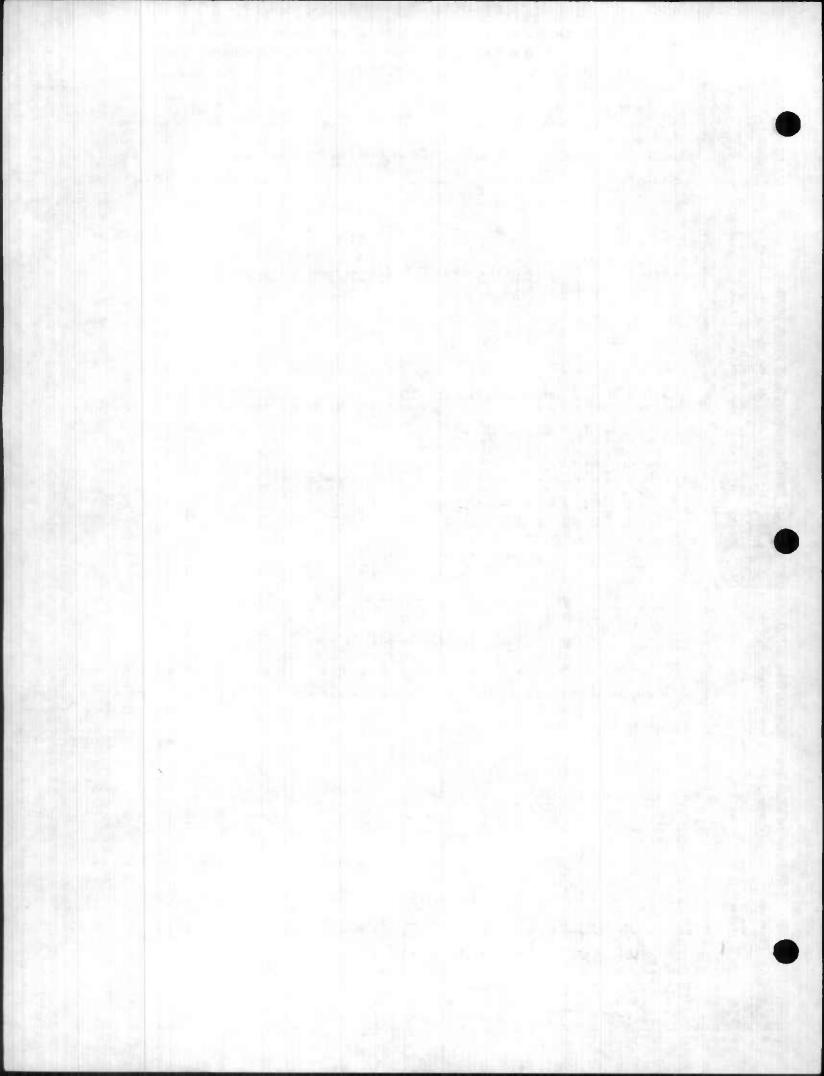
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		1. Decedent's Name (First, Middle,	Last)					2. Dete of Dea	ath		3. Time of Deeth
	Physician /Medical	Theresa Marie Do	orsie					Month Septembe	Day r 30, 20	Yeer	5:45 a.m.
	Examiner	4a Facility Name (If not institution, g					4b. City, Town, or	Location of Death			2.12 a.m.
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3	to me	Maryland Montgon	mery	Olne	ey .						1 ☐ Yes 2 ☑ No
6	or 25	10e. Street and Number				10f. Zip Co	ode		10g. Citizen of	What Country	y?
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5-0020 72 hours after de	at, or tame 23s or 28s-f show Examiner must be notified at by Funeral Director	11. Marital Status  1 Never Married 2 Merried  3 Widowed 4 Divorced	12. Wes Decedent Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:	?			t of Hispanic Origin? (: Cuban, Mexican, Pue No Specify:	Specify Yes or No- rto Rican, etc.)	Specify	e - American ck, White, etc  White	c.
21215-0020 d within 72 hours at	Completed	15. Decedent's (Specify only highest) Elementary/Secondary (0-12)		5+)	life. Do	ind of work of O NOT use i	lone during most of wo retired)	orking	16b. Kind of B		St. May
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	27 le er tras	Edward C. Dorsie	/ husband		17101	Thorn	tondale Co	urt. Olne	ev. Mary	land	20832
ore,	216	20a. Method of Disposition		20b. P	lace of Disposi	tion (Name		Oct. 2,	20c. Location		
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Baltimore,	imports any inj ance	21. Signature of Funeral Service Lic	Suber .				ddress of Fecility J. Collins Versity Bly				MD 20001
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The law	inector, page 2 s o Be Comple							101	res 2⊠ No	10	Yes 2□ No
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On Bullet	o fune	1 Netural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da	y Year)	Injury	M 200	fnjury at Work? 1 Yes 2 No	200. Describe i	low injury occur	180	
DIVIS	within 4- hours are hours are there his certificate ha completely filled in by the funeral director, page:  Medical Certification: To Be Com-	3 Suicide 6 Could not determine		jury - At ho ic. (Specify	me, ferm, stree	et, fectory, o	ffice	28f. Location (S City or Tox	Street end Numi vn, State)	ber or Rural I	Route Number,
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	8	- Farston	ANK	Dan	mo		2775		October	1, 20	000
		30. Name and address of person wh							100 00	2000	
	State	Frederick G. Bar 31. Date filed (Month, Day, Year)	r, MD 2/30				., W, Silv	er Spring	g, MD 20	1902	
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00-5473-021 State of Maryland / Department of Health and Mental Hygiene amend item 23a,27 per me G788 10/19/00 vf Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** SEPTEMBER 27, 2000 JOSEPH JAMES DOOLING 1830 PM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6404 WEATHERBY COURT FREDERICK CITY FREDERICK If Under 1 Yaar Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1X M 2□ F Months Days Hours Min Yrs. 36 Director 236-15-6769 Usual Residence of Decedent the Marytand 10a. State 10c. City, Town or Location 10b. County 10d. Inaide City Limits 28a-f show 7 is marked other than "natural", or fiams 23a or 28a-f shor traumstic event, the Madical Examinar must be notified at 1 ☐ Yas 2 ☒ No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6404 Weatherby Court 21703 USA death 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No II Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian 11. Marital Status Black, Whita, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Yaar or Datas: 1K Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White PV 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Residential Counselor Health Care 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pagas 1 and 2 should be fitted begardnern of Heelth and Mental Hungortant: if feen 27 is marked oth any Injury or other traumatic even page. Be Clarence Robert Dooling, Jr. O. Patricia Hollis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O. Patricia Dooling (mother) 2209 Glenallen Avenue #202 Silver Spring, MD 20906 20b. Place of Disposition (Nama of cematery, crematory or other placa) 20c. Location · City or Town, State Harpers Ferry, Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Peter's Cemetery West Virginia 21. Signature of uneral Service Licanses 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 Tobus an 23a. Part 1. Enter the disease, or complications that causact the death. Do not enter the mode of dylng, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical FOCAL MYOCARDIAL FIBROSIS **Examiner** Due to (or as a consequence of) Examine The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last the burial-tran and Dua to (or as a consequenca of) attanding physician P.O. Box 68760 Physician/Medical Dua to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? tha 1 Yee 2 No 3 Probably 4 Unknown signed by Records, py 2 tata has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopay performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No cartificata Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) AT SCENE 10 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Aftar 1 XX atural 5 Pending Injury after death.

Director: Aft
d in by the fur 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - Al home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide filled in within 24 hours a To the Funeral C complataly filled Hospital 1 Certifying Phyeicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified OCME SEPTEMBER 28, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYSMITS 1 KOREL 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State OCT 64 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #26,10/4/2000, BMW, Montg. Co. Reg. No 3. Time of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month 2225 Physician DILLAGO MARY Soptometre 29 SANOSTROM 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner SILUEN SANIVA Mondooner 2128 DRURY RDAO If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Yrs. 200-22-9284 April 3, 1926 Pennsylvania **Director** 74 Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flems 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Directo PA Tioga Arnot 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 16911 P.O. Box 151 Funerai 14. Race - Amarican Indian, Biack, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas: 1 Never Married 2 Married 1 Yes 2 No Specify: Specity: White by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) se filed within 7 el Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Public School System Food Service Supervisor 18. Mother's Name (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) Be Peges 1 and 2 should be 1 ment of Health end Mentel I ant: If item 27 te marked of Mary Eadie Anton F. Sandstrom 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2128 Drury Road Silver Spring, MD 20906 Sandra Rosenberg/Daughter other 20b. Placa of Disposition (Name of cametary, cramatory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date permit. Peges
Depertment of
Important: If it
eny injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 10/03/00 Brentwood, MD Ft. Lincoln Crematory 21. Signature of Funaral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CARCHOMA OF LUB-**Examiner** Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Physician/Medical that initiated events resulting in death) Last Due to (or as a consaquence of): SE 23b. Did tobacco use contributa to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to 24e. Was an autopsy performed? Completed completion of cause of death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Standard 6 College Specify residence 1 es 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

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Baltimore, Maryland 21215-0020

ician end buriel-transit physician the burie signed by to should I certificate has this After of or Attending after death.

I Director: After din by the fur To the Hospital o within 24 hours af To the Funeral Di completely filled in

20

29b. Signature

29c. Licansa number U15236

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) sorbuson ra,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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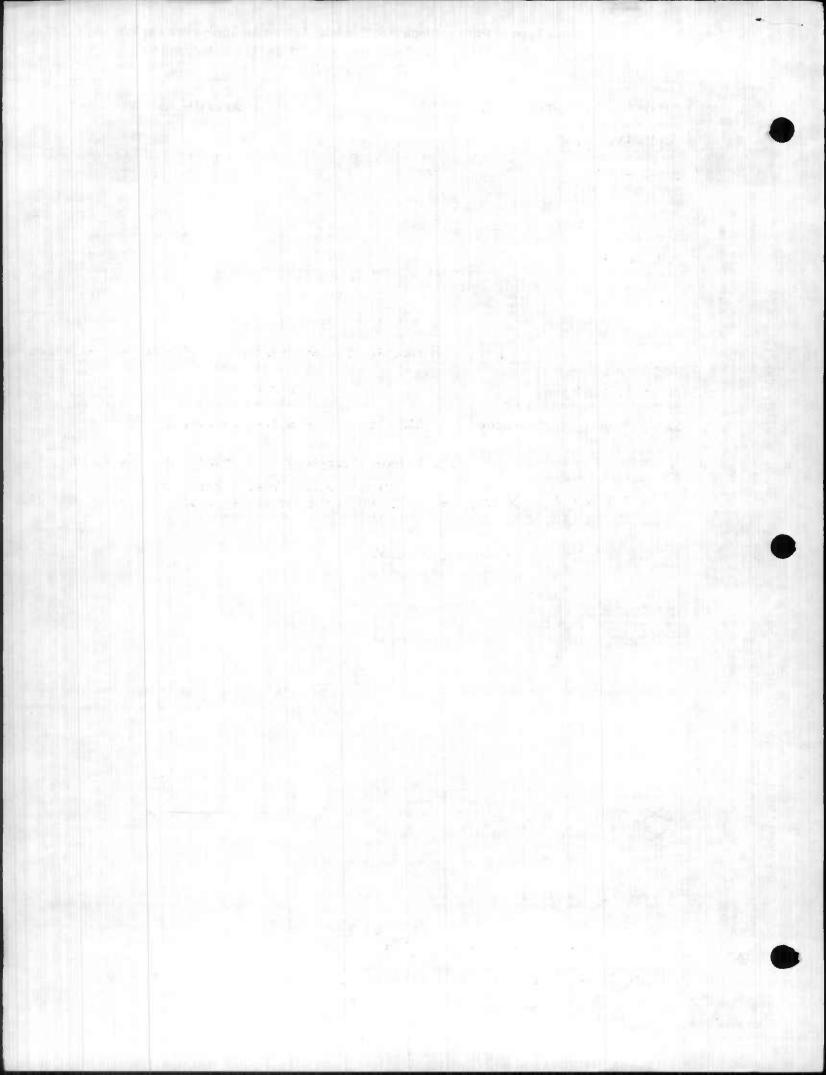
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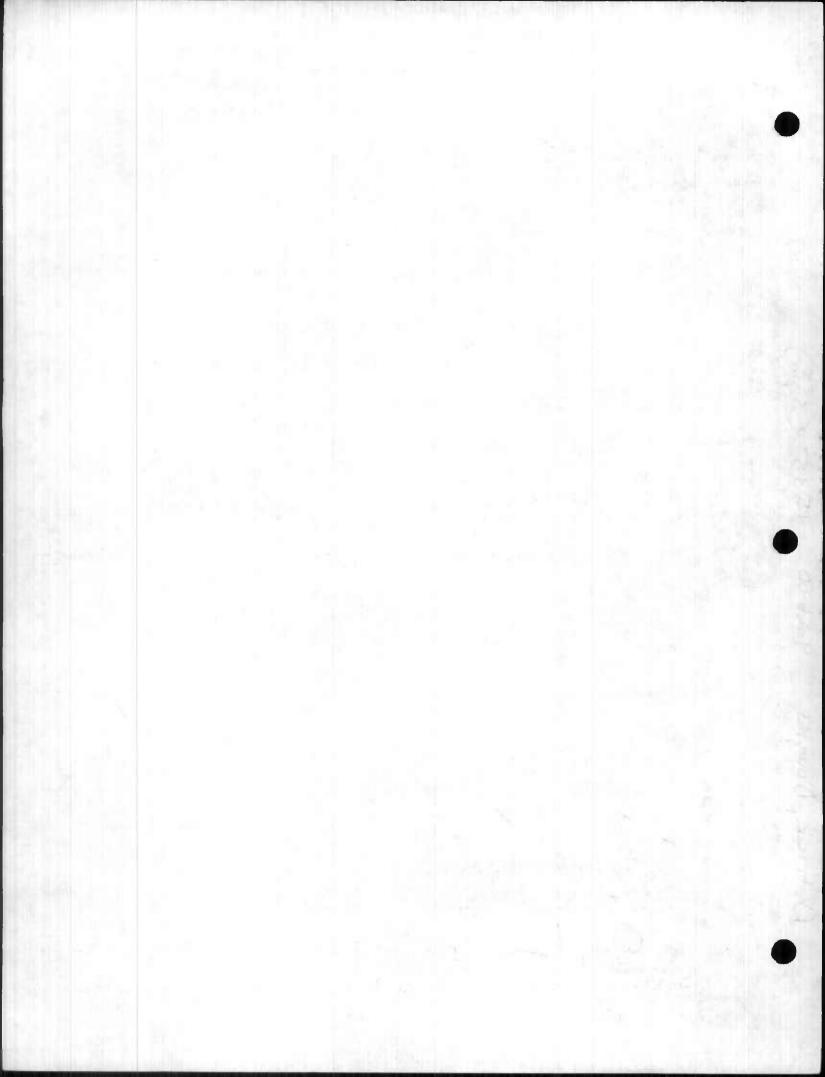
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32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene 00 32778

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December of Disposition (Name	Man Man															
MORBO3 Rockville, Maryland 20850-2805  234. Part. Enter the disease, or complications that ease the mode of dying, such as cardiac or respiratory errest.  Physician (Modelcal Examiner)	0 4187		Detrick/W					y Lan								
MORBO3 Rockville, Maryland 20850-2805  234. Part. Enter the disease, or complications that ease the mode of dying, such as cardiac or respiratory errest.  Physician (Modelcal Examiner)	0 1000		3 DRemoval from		emetery, cren	natory or off	er plac	ca)	Ser	tember	20c. Loca	ation - City	or Iow	n, State		
MORBO3 Rockville, Maryland 20850-2805  234. Part. Enter the disease, or complications that ease the mode of dying, such as cardiac or respiratory errest.  Physician (Modelcal Examiner)	E gath				teomerv	Cremat	ori	m. Ir	ic. 30	. 2000	Beth	esda.	Ma	rvland		
MORBO3 Rockville, Maryland 20850-2805  234. Part. Enter the disease, or complications that ease the mode of dying, such as cardiac or respiratory errest.  Physician (Modelcal Examiner)	The state of	21. Signature of Femeral Service	Licensee		22	. Name and	Addre	ss of Facilit	y Robe	ert A.	Pump!	hrey	Fun	eral Hom		
Physician // Committee in the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory errest.    Approximate   Committee   Committe		1 - 00	= 0										y A	venue		
Physician   Model call   Examiner	10	non Ports Fater the diseases	5	-	Innovimato											
Immediate Cause (Final disease or conditions)  Beguenitally list conditions, graph c		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.												nterval Between		
Season of condition of season of conditions of con													10	January and Death		
Sequentially list conditions, and property of the inflicted events in resulting in death but not resulting in the underlying cause given in Part I.    Due to (or as a consequence of):		disease or condition	Non	SMALL	CELL	Lun	1	mi	h				10	month		
Sequentially list conditions, and property of the inflicted events in resulting in death but not resulting in the underlying cause given in Part I.    Due to (or as a consequence of):		Due to (or as a consequence of):														
Ceuse (Disease or influent conditions contributing to death but not resulting in the underlying cause given in Part I.    Comparison of the conditions of the conditions contributing to death but not resulting in the underlying cause given in Part I.   Conditions of the conditions of the conditions contributing to death but not resulting in the underlying cause given in Part I.   Conditions of the conditio		b														
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The state of the s	8760, sate be associted by spician and the bunal-transit	Sequentially list conditions, Due to (or as a consequence of): if any, leeding to immediate cause. Enter Undertying														
The state of the s	766 B Sicie	cause. Enter Underlying Ceuse (Disease or injury that initiated events  Due to (or as a consequence of):														
The state of the s	ficat ficat	resulting in death) Last	that initiated events resulting in death) Last  Due to (or as a consequence of):													
Per II. Other eigninicant conditions contributing to death but not resulting in the underlying cause given in Part I.    1   Yes   2   No   3   4   No   4	X 6 5 9	d														
Per II. Other eigninicant conditions contributing to death but not resulting in the underlying cause given in Part I.    1   Yes   2   No   3   4   No   4	Batte Part	a.														
246. Wes an autopsy performed?  246. Wes an autopsy performed?  247. Wes an autopsy performed?  248. Wes an autopsy performed?  249. Were autopsy finding available prior to completion of cause of death.  259. Was case referred to medical examiner?  250. Was case referred to medical examiner?  260. Place of Death (Check only one)  270. Manner of Death Death Death of Death D	O 5 5 5 5	Pert il. Other eignificant conditie	one contributing to	death but not res	ulting In the ur	nderlying ca	use giv	en in Part I				1	)			
24b. Was an autopsy performed?  24c. Was as a referred to medical examiner?  1   Yes   2   No   No	d by de by									10	Yes 2	No 3	Probi	ibly 4 Unkr		
The state of the s	S 5 8 4												4h 144			
The state of the s	To some											y 24	avai	leble prior to		
26. Place of Death (Check only one)  27. Manner of Deeth	0 > 20 00 -									-			of de	eath?		
26. Place of Death (Check only one)  27. Manner of Deeth	The he had a									10	Yes 2	No	10	Yes AT No		
Continue of the continue of	Ficat Y. P.							06 DI-	and Darett	1				1		
Manner of Deeth    27. Manner of Deeth   28. Date of Injury   28. Date o	Centi		Hoepital:	1 -	EDIC :		Oth	or:				De:	0- "	1		
State   Stat	This hy		1)				1	4 LIN					Specify)			
29a. Certifying Phyelclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Phyelclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signeture and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. State  31. Date filed (Month, Day, Year)  32. Registrar's Signature  A Cartifying Phyelclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signeture and title of certifier  29c. License number  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Ing Ing	atural 5 Pendi	ng (Mo							ou. Describe	HOW HIJUTY	Joourned				
29a. Certifying Phyelclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Phyelclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signeture and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. State  31. Date filed (Month, Day, Year)  32. Registrar's Signature  A Cartifying Phyelclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signeture and title of certifier  29c. License number  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Sic eath or:	2 Accident investi	not he					105 2LI			100	**				
29a. Certifying Phyelclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Phyelclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signeture and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. State  31. Date filed (Month, Day, Year)  32. Registrar's Signature  A Cartifying Phyelclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signeture and title of certifier  29c. License number  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	IVI Fer d	4 Homicide determ	nined 28e. Plac	ca of Injury - At he ding, etc. (Specify	ome, farm, str	eet, factory,	offica		2	City or To	(Street and own, State)	Numbero	r Hurai	Houte Number,		
29a. Certifying Phyelclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Phyelclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signeture and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. State  31. Date filed (Month, Day, Year)  32. Registrar's Signature  A Cartifying Phyelclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signeture and title of certifier  29c. License number  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	O of Control															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JOSEPH KARLAW, MO 1811 PRING PLIN, DR OLNEY, MO. 20832  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	hour hour ly fill	29a. Certifier Certifyla	Phyelclen: To th	ne best of my kno	wledge, death	occurred a	t the tir	ne, date an	d place, a	nd due to the	cause(s) a	ind manne	er as sta	ted.		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JOSEPH KARLAW, MO 1811 PRING PLIN, DR OLNEY, MO. 20832  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	Nete Fi	one) 2 Medical			tion and/or inv	vestigation,	in my o	pinion, des	un occurre	u at the time,	, dete end p	nace, end	due to t	rie Cause(s)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JOSEPH KARLAW, MO 1811 PRING PLIN, DR OLNEY, MO. 20832  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	omb comp		or /			29c.	Licens	e number			29d. Date	signed (N	Aonth, D	ay, Year)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JOSEPH KAPLAN, MD 1811 PRINT PLINT PLINT OUNEY, MD 20832  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature		1 6 450	1 -	m	111	D	3	567	-		SEPTE	mar	-0	26 20		
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature of Specific According to the State of Specific According to the Specific According	u	1 1		<u> </u>		210		0 0	, )			77	-1	,		
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature								De	01 -	154	ma	70	780	>		
OOT 6 9 2000 Married 19 Appellat		21 Date filed (Month Day Year				17.1	C	7.0		י דים י	, ,		- 0 >			
	State Registra	OOT G		Hagistrar's Signa	19	has	W. M.	21								

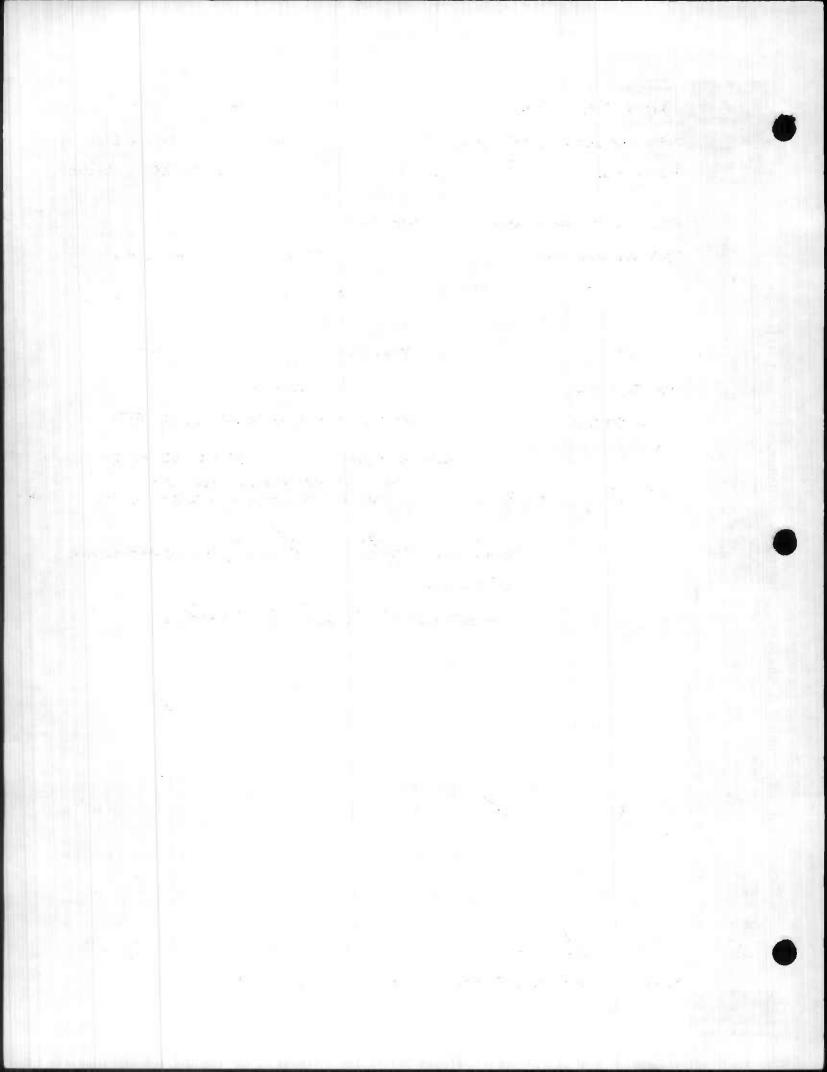


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Daath Day Month Yaar **Physician** 29, 2000 8:45am Sept. Camde Nguyen Dang /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street end number) Examiner Prince Georges Prince George Hospital Center Cheverly If Undar 1 Year if Undar 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sax 7. Age (In vrs. last birthday) 8. Data of Birth (Month, Dey, Yeer) **Funeral** Days 1□M 21XF Hours Months 68 Nov. 23, Vietnam Director 215-94-4092 Usual Rasidence of Decedant with the Marylend 10c. City, Town or Location 10d, insida City Limits 10a. Stata 10b. County r than "natural", or items 23a or 28a-f show the Medical Experient must be notified at 1 ☐ Yas 2 💢 No Directo Maryland Prince Georges Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20770 United States 7905 Ora Glen Drive Funeral filed within 72 hours after death 14. Race - American Indien, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 1 Nevar Married 20 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: Asian by 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Hygiene. Elamentery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home marked other 18. Mothar's Nama (First, Middle, Meiden Sumeme) 17. Fethar's Nema (First, Middle, Last) permit. Pages 1 end 2 should be file.
Department of Health end Mental Hy
Important: if item 27 is marked othe
any Injury or other traumatic event
any Injury or other traumatic event Be Oanh Ho Vung T. Nguyen 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Nama/Ralationship (Type, Print) 7905 Ora Glen Drive Greenbelt, MD 20770 Tri N. Dang/Son 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 X Buriel 2 ☐ Cramation 3 ☐ Ramoval from Stata 10/02/00 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Silver Spring, MD 22. Nama and Addrass of Facility
Hines-Rinaldi Funeral Home, Inc. 21. Signeture of Funeral Service Licenses low 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part1. Entar tha disassa, or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intarvel Between Onsat and Daath **Physician** /Medical Immediata Causa (Final disaese or condition resulting in death) Examiner Due to (or as a consequenca of): Examiner -trensit The law requires that the deeth certificate be executed end Sequentially list conditions, if any, laading to immediata cause. Enter Undarlying Cause (Diseasa or injury that initieted avents rasulting in daath) Last Due to physician e s the burial-Box 68760. Physician/Medical Due to (or as e consequence of). ettending p 98 23b. Did tobaccq use contribute to the cause of death? Part ii. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the should be detached Division of Vital Records, P.O. ZONO 3 Probably 4 Unknown by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy periormad? Completed page 2 s r this certificate haral director, page 1 ☐ Yas 2 ☐ No 1 Yes or Attending Physician: The safter death.

I Director: After this certificate in by the funeral director. pa Be 25. Was casa refarred to medical axaminar? 26. Placa of Daath (Check only one) Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) Hospital: 2 1 Yas Inpatiant 2 ER/Outpetient 3 DOA 27. Mariner of Dae 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Dascribe how injury occurred Certification: 28b. Tima of 5 Panding invastigation Naturai 1 Yas 2 No 2 Accidant 6 Could not be detarmined 3 Suicide 28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide within 24 hours aft To the Funerel DI completely filled in To the Hospital 29a. Cartifiar Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. Licensa number 0 30. Nama and address of person who completed causa of daeth (itam 23e) (Type, Print) Catavenis, MD 3001 Hospital Drive Cheverly, MD 20722 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32780 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death DODA 7-23 PM DOUGLAS 10 10 00 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death LAUREL REGIONAL HOSPITAL LAUREL Prince George's If Under 24 Hrs. Hours Min. 6. Sex 12 M 2 ☐ F If Under 1 Year 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 217-44-7014 Virgínia Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes XXNo Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3355 Sudlersville S. 20724 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 1 Never Merried 2 Merried 1 X Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Construction 12 Mechanical Contractor 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Virginia Judith Purks William Andrew Dodd, Sr. 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3355 Sudlersville S. Laurel, MD 20724 Mary R. Dodd/Wife 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stele 20e. Method of Disposition 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from Stete 10/16/00 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, Maryland 20707 MO1103 23a. Pent1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth ACUTE MYOCARDIAL INFARCTION Immediate Cause (Final diseese or condition resulting in deeth) Due to (or es a consequence of): CORONARY ARTERY DISEASE 7 years Due to (or es e consequence of) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting In death) Last RTERIOSCLEROSIS PERLIPEDEMIA 23b. Did tobacco use contribute to the cause of death? HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were sutopsy findings aveilable prior to completion of cause of death? DIABETES MELLITUS 24a. Wes an eutopsy performed? 1 ☐ Yes 2 No 26. Placa of Deeth (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. Stete

Director

Funeral

Be

**Funeral** Director

ò

21215-0020

Maryland

altimore,

Box

Division of Vital Records.

Physician/Medical 2q Completed Be

Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Was case referred to medical exeminer?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth

28e. Dete of Injury (Month, Day Year) 5 Pending investigation

28b. Time of

28e. Pieca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury et Work?

1 Yes 2 No

28d. Describe how injury occurred

29a, Certifier

1 Netures
2 Accident

3 Suicide

4 ☐ Homicide

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examinar: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture and title of cartifier/

6 Could not be determined

29c. License number D 21294 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

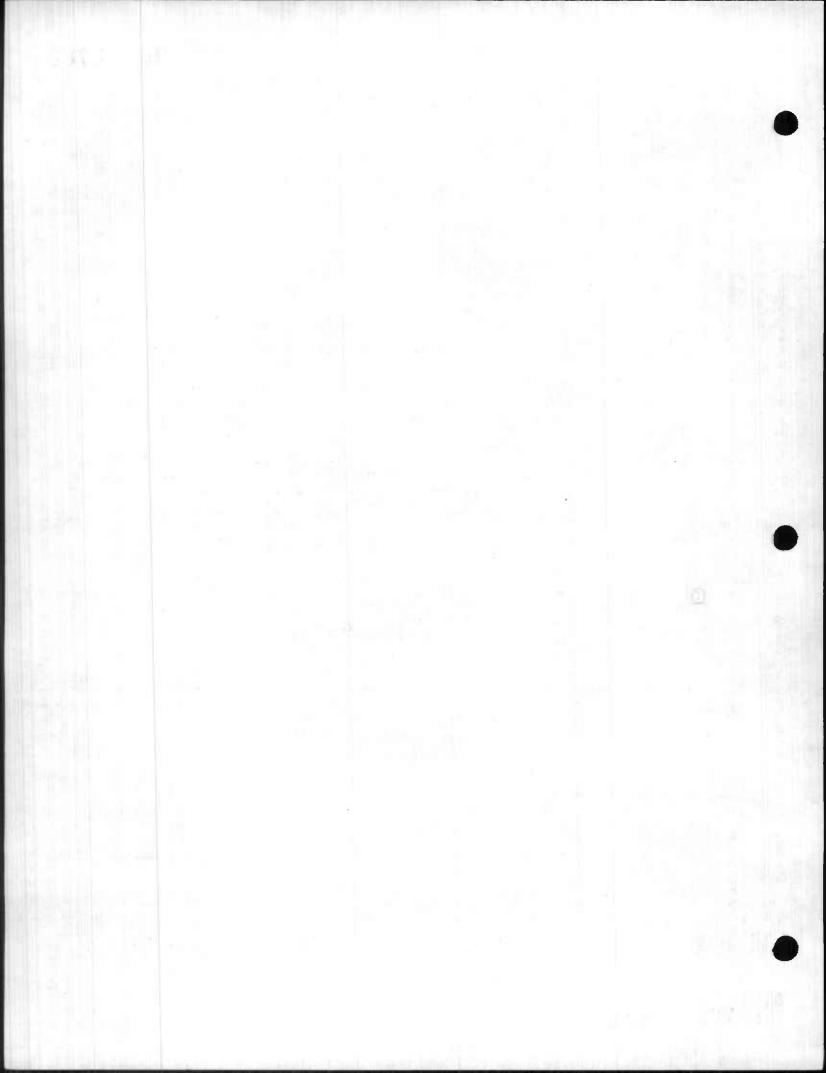
Juse of death (Hern 23a) (Type, Print)

M.D. 3450-FORT MEADE ROAD SUITE 100 LAUREL,

M.D. 20724 31. Dete filed (Month, Day, Year)

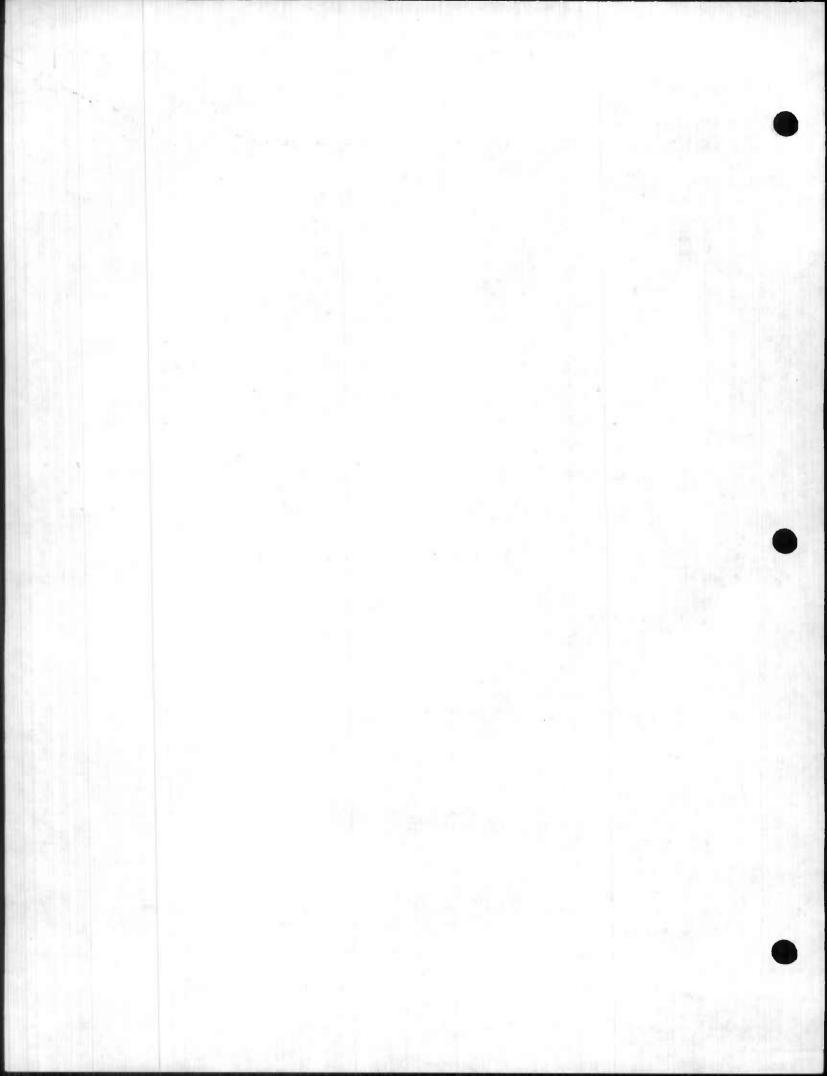
Registrar

32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene

	Certificate of L	Death Reg. No. UU 32/81								
Physician	1. Decedent's Name (First, Middle, Last)  WILLIAM L. DUNTON	2. Dete of Death Month Dey Year 1535								
/Medical		ib. City, Town, or Location of Death  4c. County of Death								
Examiner		0								
	15. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	2000117101117								
Funeral Director	216-40-1851 1♀M 2□ F 57 Yrs. Months Days Usual Residence of Decedent	If Under 24 Hrs.   8. Date of Birth (Month, Dey, Year)   9. Birthplaca (Stete or Foreign Country)   Jan. 22, 1943   Maryland								
ehow start	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits								
Men to	Maryland Howard Woodstock	1 ☐ Yes 2 🔀 No								
vith the Me or 28a-f o be recorded	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?								
th wil	10532 Chesham Way 211	United States								
To Be Completed by Funeral Director	3 Widowed 4 Divorced Year or Dates:	ispanic Origin? (Specify Yes or No- n, Mexican, Puerto Rican, etc.)  Specify:  14. Rece - American Indian, Black, White, etc.  Specify: white								
ed within 72 ho. ygjene. or than "naturi ft, the Marcell Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done of	etion 16b. Kind of Business/Industry								
en in	(Specify only highest grade completed)  (Give kind of work done of life. DO NOT use retired.)  Elementary/Secondary (0-12)  College (1-4or 5+)	O. D. Departuicit								
2 5 5 C	3 Transportation									
De fill d oth	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumeme)								
should be fill and Mentel H marked off umatic even	William M. Dunton	Ruth H. Doney								
200		end Number or Rural Route Number, City or Town, State, Zip Code)  n Way Woodstock, MD. 21163								
2 1 2 2	20a. Method of Disposition  1 Removal from State  4 Donation 5 Other (Specify)  20b. Piace of Disposition (Neme of cemetery, crematory or other plecting of the complete of the complete of the cemetery of the cemetery of the cemetery.	COT								
permit. Page Department of Important: If any injury or once.	21. Signature of Funeral Service Licensee 22. Name and Addres Harry H. W.	itzke's Family Funeral Home, Inc.								
Physician /Medical Examiner	tmmediate Cause (Final disease or condition resulting in death)  a. MYOCAROIAL INFA  Due to (or as e consequence of):	RCTON Onset and Death								
icate be assecuted physician end s the burial-transit										
5 0 6	resulting in death) Last  Due to (or as a consequence of):									
the attending the for use	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I. 23b. Did tobacco use contribute to the cause of deat								
ss that the death certigned by the attending be detached for use a by Physician/M	DIABETES MELLITUS, ATRIAL FIBRILLATION									
been should	HYPBRLIPIDEMIA	24e. Was an autopsy performed?  24b. Were autopsy finding available prior to completion of cause of death?								
certificate has rector, page 2		1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No								
s certificate he director, page	25. Wes case referred to medical examiner?	26. Place of Death (Check only one)								
7 50	1 Yes 25 No Hospital: 1 Inpatient 25 ER/Outpatient 3 DOA Other	er: 4 Nursing Home 5 Residence 6 Other (Specify)								
Attending Ph r deeth. ector: After th by the funeral	27. Menner of Death 1 Netural 5 Pending 28a. Dete of Injury 28b. Time of Injury World 1 Netural 5 Pending 28c. Injury 28c. I	y at 28d. Describe how injury occurred k? Yes 2□No								
	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)								
To the Hospital or within 24 hours after to the Funeral Dir completely filled in Medical Cert	29a. Certifier (Check only one)  Certifying Physician: To the best of rny knowledge, death occurred at the tin one)  Medical Examiner: On the basis of examination and/or investigation, in my of and menner stated.									
withir To the comp	29b. Signeture and title of certifier 29c. License	e number 29d. Date signed (Month, Dey, Year)								
	Marchall treatmen, D.O. H3	37211 007, 6, 2000								
11000	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Narhall Freedman, 2 KNULL N, COLL	MBIA MD 2/045								
State	31. Date filed (Month, Dey, Year)  32. Registrer's Signature  Apark	2/								



State of Maryland / Department of Health and Mental Hygiene 00 32782

Examiner and be notified at Examiner and Examiner and Examiner and Examiner at	4e Fscility Name (If not Institution 5 Enid Court 5. Sociel Security Number 501-09-8300 Usual Residence of Decedent 10a. Stete 10b. County	Martin n, give streat and nu 6. Sex 1□ M 2♥F	7. Age (In yrs.	. last birthday) 33 Yrs.	Edwa	r 1 Yeer	_	toma	cation of Deeth	Day 28, 2000 4c. County Monts	of Death	3. Time of Death 7:20 AM  Ty  place (State or Forestry)				
/Medical Examiner Funeral Director	4e Fscility Name (If not Institution 5 Enid Court 5. Sociel Security Number 501-09-8300 Usual Residence of Decedent 10a. Stete 10b. County MD Mont	n, give streat and nu 6. Sex 1 □ M 2 🎇 F	7. Age (In yrs.		lf Unde	r 1 Yeer	P c	toma 24 Hrs.	cation of Deeth	4c. County Monts	of Death	у				
Examiner Funeral Director	5 Enid Court  5. Sociel Security Number  501-09-8300  Usual Residence of Decedent  10a. Stete 10b. County  MD Mont	6. Sex 1 □ M 2 ሺ F	7. Age (In yrs.			r 1 Yeer	P c	toma 24 Hrs.	ac	Montg	gomer					
Director	5. Social Security Number  501-09-8300  Usual Residence of Decedent  10a. State 10b. County  MD Mont	1□ M 2\ F					If Under:	24 Hrs.			-					
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	Usual Residence of Decedent 10a. Stete 10b. County MD Mont		8	33 Yrs.	William	00,0	110010				COU	ntry)				
T must be notified at neral Director	MD Mont										Nort	h Caroli				
r must be notified at neral Director	MD Mont															
r must be notified resident Director			10c. Ci	ity, Town or Lo	ocation							10d. Inside City Lin				
r numbe nor 28 r numbe nor	10e. Street and Number	gomery		Chevy	Cha	se						1 X Yes 2□				
rma 23a o rmantb			8		10f. Zi	o Code				10g. Citizen of V	Vhat Cou	ntry?				
Teris	8101 Connection	cut Ave	#N509			2081	5			U.S.A.						
	11, Marital Stetus	12. Was Dec	edent Ever in L	J,S. 13.	Was Dece	dent of H	lispanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	- 14. Rac		can Indien,				
44 D	1 Never Married 2 Merr	rled 1 X Yes	2 No					, Puerto	Hican, etc.)	Blac	ok, White,	etc.				
by by	3 ₩ Widowed 4 □ Divorced	If Yes, Gi	ve Dates: WW	II	1 Yes	2 No	Specify:			Specify	Whi	lte				
"natural".	15. Deceden	nt's Education		16a. Dece	dent's Usu	el Occup	etion			16b. Kind of Bu						
d other than "nature event, the Madical Be Completed		st grade completed)		(Give	DO NOT	ork done o ise retired	during most	of worki	ng							
E E	Elementary/Secondary (0-12)	College (	1-40r 5+)	Admin	nistr	ative	e Ass:	istai	nt	U.S.	Senat	e				
ther than	17. Father's Neme (First, Middle,			Tagain 201	ITOUL					Maiden Suman						
arked out	Dotmiol I N	Martin					Date	ricia	Carn	ontor						
marked other than martic event, that is To Be Comp	Patrick J. M. 19a. Informant's Name/Relations	Martin	1	10h 14all	ing Addes	e (Stract				enter er, City or Town,	State 7	Code1				
9 2											Jiaio, Zij	, 5006)				
ther tr	Victoria L. Edw	vards (Da	aughter	) 5 End			Pote	omac	, MD 20	20c. Location -	City or To	own State				
42 3	1 Burial 2 Cremation	3 Removal from		cemetery, crei	matory or	other plac	ce)	1	Date	200. LOGATION	Only of 1	JWII, GIAIO				
45 4	4 Donation 5 Other (S	Specify)	Na	tional	Crem	ator	У	1	0-02	Falls C	hurcl	h, VA				
important: If frem 27 any injury or other tr	21. Signature of Funerel Service	Licensee		_ 22	2. Name a	nd Addre	ss of Facilit	× 901	NS, INC							
8 2 2 8	Muy B	Pur									ton.	DC 2001				
	23a. Part1. Entet un dinnese, or	complications that	caused tha dea									Approximate				
sician	shock, or heart fàildre. List only one cause on each line.  Intervel Between Onset and Death Immediate Couse (Final disease or condition Colon Cancer															
ledical	Immediate Ceuse (Final disease or condition a Colon Cancer years resulting in death)															
aminer	disease or condition resulting in death)	onset and Dea														
- T	Due to (or as a consequence of):															
n end ial-transit Examiner		equentially list conditions.  Due to (or as a consequence of):														
end II-tra	equentially list conditions, any, leading to immediate ause. Enter Underlying															
bunia B	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):  Due to (or as a consequence of):															
g physicien end as the bunal-transit fedical Examir	resulting in death) Last		Due to (d	or as a conseq	quenca of)						1					
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tor use a						10										
ysic	Part II. Other significant condition		23b. Did	tobscco use co	ntributs t	o the cause of de										
F 50	None								10	Yee 2∑ No	3 Pro	bably 4 Unk				
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should should										an autopsy ormed?	81	fere autopsy findir vailable prior to				
97 CL											of	ompletion of cause death?				
page 2									10	Yes 2 No	1	☐ Yes 2☐ No				
cartificate rector, pag	25. Was case referred to medical	1					26 Place	of Death	n (Check only							
	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	Innationt OF	TED/Outpotion	ent 3□ D	OA Oth	er.			**	da	ughter's				
E = -	27. Manner of Death	28a. Date	of Injury	28b. Time o		28c. Injur Wor	4 LI NU	-	me 5 Resi 28d. Describe	how injury occur	_	reside				
0 2	1 X Natural 5 ☐ Pendin	ng (Mon	nth, Day Year)	Injury	M		k? Yes 2□									
S S		not be	e of Injury - At h	nome farm et		-			28f. Location (	Street and Num!	per or Rur	al Route Number,				
y the fur	3 ☐ Suicide 6 ☐ Could	build	ing, etc. (Speci	ify)		71 011100			City or To	wn, State)						
by the	Z L MOOIOOIN				La La	1 - 4 - 4		4 -1								
by the	3 Suicide 6 Could determ		1 1			at the tin	ne, date an	d place.	and due to the	cause(s) and ma	anner as	nratari				
by the	3   Suicide 6   Could determ 4   Homicide    29a. Certifier   1   Certifyin   Check only   2   Medical	Examiner: On the b	asis of examina	owledge, deatl ation and/or in	th occurred evestigation	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner in the cause (s) and manner in the										
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by the	3   Suicide 6   Could determ 4   Homicide 29a. Certifier (Check only one) 2   Medical	Examiner: On the b	asis of examina	owledge, death ation and/or in	estigation 29	n, in my o	pinlon, dea	th occurr	ed at the time,	date and place,	and due to	Day, Year)				
To the Funeral Director:  completely tilled in by the	3   Suicide 6   Could determ 4   Homicide 29a. Certifier (Check only one) 2   Medical	Examiner: On the band man	easis of examination stated.	ation and/or in	evestigation 29	n, in my o	pinlon, dea	th occurr	ed at the time,	date and place, 29d. Date signe	and due to	Day, Year)				
To the Funeral Director: completely tilled in by the	3   Suicide 4   Homicide  29a. Certifier (Check only 2   Medical  29b. Signeture end title of certifie	Examiner: On the band man	asis of examination stated.	ation and/or in	29, Print)	n, in my o	pinlon, dea e number 43	th occurr	ed at the time,	date and place, 29d. Date signe	er 2	Day, Year) 9, 2000				



State of Maryland /'Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 **Physician** JOHN FALLON 1510 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 13299 ROLLIE RD. EAST BISHOPVILLE WORCESTER 5. Social Security Number 147 - 22 - 2101 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 8-2-31 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2□ F Months Hours 69 Yrs. Director Usual Residence of Decedent deeth with the Menyland 10a. State 10b. County 10c. City, Town or Location - Nove 10d. Inside City Limits 1 Yes 2 No Director BISHOPVILLE MD. WORCESTER 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13299 ROLLIE RD. 21813 EAST U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S.
Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Notil Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'naturel', or items Black White etc. 1 RYes 2 No 1948 If Yes, Give Year or Dates: 1072 Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. 1 Never Married 2 Married Saitimore, Maryland 21215-0020 1 Yes 2 No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry bith and Mental Hygiens. 27 is marked other than "n r treumatic event, the Hea Elementary/Secondary (0-12) College (1-4or 5+) ADJUSTER INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN J. FALLON SR. 0 MARGARET FAHEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13299 ROLLIR RD. EAST BISHOPVILLE, Mp.21813 important: If Item 27 I JUDITH FALLON/ SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD. VETERANS CEM. 10 - 4Depentment HURLOCK, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD. This that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. 23a. Part 1 Enter the disease, or complication shock, or heart failure. List only one can Approximate Intervat Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760, Due to (or as ate has been signed by the a page 2 should be detsched i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld 1 bacco use contribute to the cause of death? 1 Yes 2□ No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 Yes 210 No 1 □Yes 2 □ No certificate Division of Vital or Attending Physicien: director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 2 No Medical Certification: To 1 ☐ Y#s 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 100 27. Manuer of D 1 Natural er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. tnjury at Work? After 5 Pending investigation To the Hospital or Attendit within 24 hours effer deeth. To the Funeral Director: At 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signarua end Title of certified 29c. License number 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) 1006 State Registrar



State of Maryland / Department of Health and Mental Hygiene

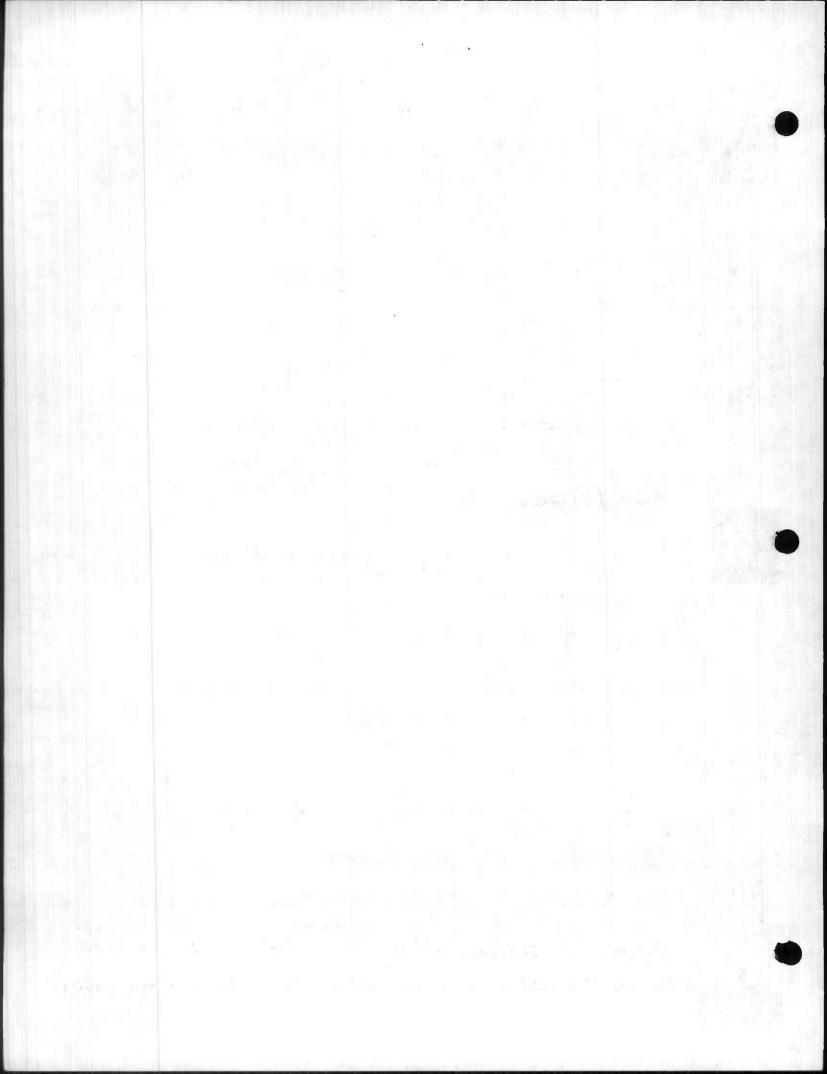
32784 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth Month 10 **Physician** LaVelta Flora 02 2000 1:20 am /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Hartley Hall Nursing Home Pocomoke City Worcester 5. Sociel Security Number If Under 1 Year | if Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth Birthplece (State or Foreign Country) **Funeral** 1□M 2[XF Months Deys Hours 85 Yrs. Director 478-68-5589 03/08/1915 Kansas Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Director Somerset Westover 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? natural', or items 23a or Funeral 7155 Elmo Dryden Road 21871 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Reca - American Indien, Bleck, White, etc. 11. Maritel Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à Specify 3 Widowed 4 □ Divorced white Completed Decedent's Usuel Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Haelih and Mental Hygiens Important: If Hem 27 is marked other that any Injury or other traumatic event, Ital. Sings. 12 Homemaker Domestic 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Joseph Oxley Emma Long 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 7171 Elmo Dryden Rd., Westover, MD 21871

20b. Pleca of Disposition (Name of cemetery, crematory or other plece)
Holly Grove Memorite
Church Cemetery 10/05/00 Westover, M Ellen Moyer (daughter) 20e. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 10/05/00 Westover, MD 21. Signeture of Fundrel Servica Licensee 22. Neme end Address of Fecility Holloway Melson Funeral Home, P.A. mo1129 103 Linden Ave., Pocomoke City, MD 21851 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in death) **Examiner** Physician/Medical Examiner The law requires that the daath certificate be axecuted attending physician and for use es the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760, Due to (or es e consequença of) P.O. 1 signed by the at the detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2⊠ No 3 Probably 4 Unknown Records, P page 2 should Completed 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital i efter deeth.

I Director: After this certification by the funeral director, or Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4⊠ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 27. Menner of Deeth Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending Investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours of To the Funeral Di filled 150 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end place, end due to the ceuse(s) end manner stated. 29a. Certifier Medical completaly (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) ne and indress of person who completed cause of deeth (Item 23e) (Type, Print) GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY DR., SALISBURY, MD 21801
31. Dete filed (Month, Day, Year) 3 2000 32. Registrer's Signeture G. Angell. State

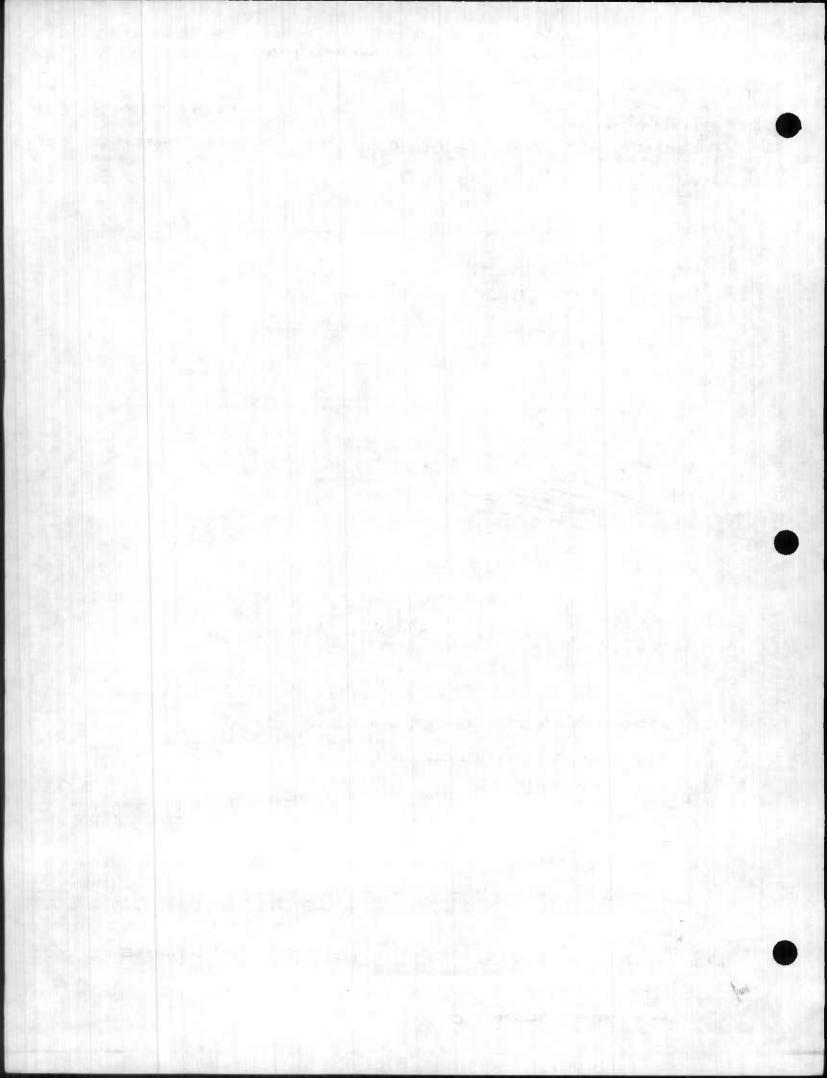
Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** FELTON SEPTEMBER 25,2000 1:07 AM HOWARD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner OF MARYLAND HOSPITAL BALTIHORE, MURILAND BALTIMORE CITY UNIVERSITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 F 226-34-3943 76 Director July 3,1924 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inaide City Limits 10b. County 1 Yes 2 No Directo Pocomoke Maryland Worcester or flams 23a or 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 106 21851 USA Funeral Cherry Street Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? 11 Maritel Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify à 3 Widowed 4 Divorced **Black** 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Gardener Own Business 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H lant; if from 27 is mented off Wood 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stele, Zip Code) Mable Felton / wife 106 Cherry Street, Pocomoke, Maryland 21851 Saltimore, 20b. Placa of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/2/2000 Veterans Cemetery Hurlock, Maryland 21. Signature of Funeral Seguice Licenses 22. Name and Address of Fecility Bennie Smith Funeral Home P.O.Box 1687, Easton, Maryland 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner Hypoxemia The lew requires that the deeth certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hemorrhage P.O. Box 68760, iffuse Alvedo Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? detached 2 DAG 3 Probably 4 Unknown 1 Yes signed by Division of Vital Records, Be Completed by 24a. Was an autopsy 24b. Were eutopsy findings available prior to completion of cause of death? page 2 1 105 2 No Hypertensio 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Depatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2000 Certification: To this 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred After 1- Natural 5 Pending after deeth. Director: Aft 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide filled in within 24 hours a To the Funeral C completely filled Hospital Cortifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) and manner stated. Medical 29a, Certifier To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of cartifier SEPTEMBER 25, 2000 -ec 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIPLE HANSALIA, HD: 22 South Greene SWEET, BALTIHORE, MARYCAND 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 0 2 2000 DOUKE

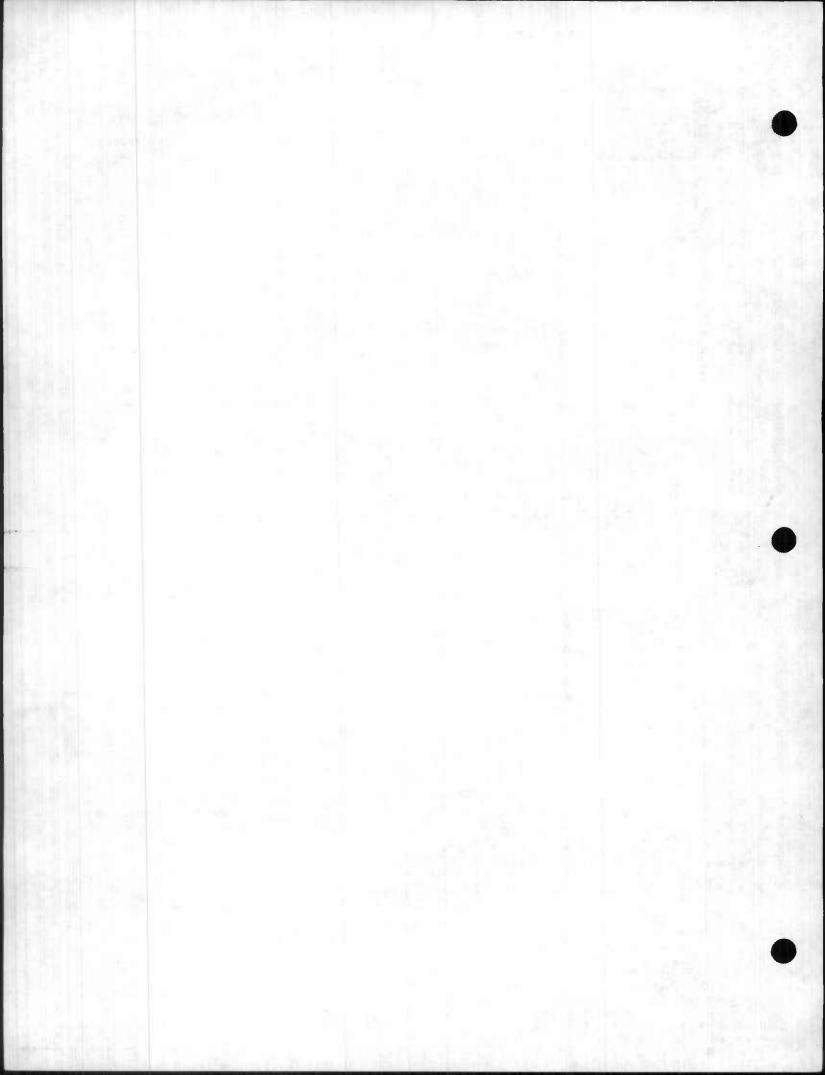


State of Maryland / Department of Health and Mental Hygiene 00 32786

				Ce	rtificate o	of Death	1		Reg. No.	, 0	22100				
	1. Decedent's Nama (First, Mide	dia, Last)			MAL.			2. Data of De Month	ath Day	Yaar	3. Time of Death				
Physician /Modical		Alic	ce Barret	Fra	ncis			Septem			20:45				
/Medical Examiner	4a Facility Nama (If not instituti	ion, give street end n	umber)			4b. City, T	own, or L	ocation of Deeth		nty of Death					
	Suburban H	ospital				Beth	esda		Mon	tgomer	У				
Funeral	5. Social Security Number	6. Sax	7. Aga (In yrs. las	birthdey)	If Undar 1 Ya		r 24 Hrs. Min.	8. Date of Bir (Month, De	th V. Year)	9. Birthp	olaca (Stata or Foreign				
Director	199-14-6846	1□M 2∏F	77	Yrs.	WOTHITS Day	ys Hours	14601.	December	27,192	2 Per	insylvania				
9 .	Usual Residence of Decedent		140- 00- 3								od toda Ohitinh				
show and	10a. Stata 10b. Count		10c. Gity, 1								1 ☐ Yas 2 ☑ No				
Maria Maria		gomery	Po	otoma											
or 28s-f s be notified Director	10e. Street and Number				10f. Zip Code			200	10g. Citizen o						
23s rail	11309 Gain					854				d Stat					
r terms 23s or 23s-1 shownings. must be notified at Funeral Director	11. Meritel Stetus	Armed F	cedant Ever in U,S. orces?	13.	Was Decedant of If Yas, specify C	of Hispanic O Juben, Maxica	rigin? (Sp ın, Puerto	ecify Yes or No Rican, atc.)	- 14. R	ace - Amaric lack, White,					
by B	1 □ Never Married 2 ☑ Ma 3 □ Widowed 4 □ Divorce	If Yas, G			1□ Yas 2∭ N	No Specify	<i>r</i> :		Spec	city: Wh	nite				
operation 'natural, the Medical	15. Deceda (Specify only high	nt's Education ast grada complated	)	6a. Dece (Giva life.	dant's Usuel Oci kind of work do DO NOT usa ret	cupation na during mo tired)	st of work	ring	16b. Kind of	Businass/In-	dustry				
The Man	Elementary/Secondary (0-12)	Cotlege	(1-4or 5+)		maker/A				Own	Home					
	17. Fathar's Name (First, Middle	e, Last)					ar's Nam	a (First, Middle,	Maiden Sum	ama)					
arked off affic ever To Be		e T. Barre	ett					te Walt							
-	19e. Informant's Neme/Relation			19b. Maiti	ing Addrass (Stre	eet and Numi	ber or Rui	ral Routa Numb	er. City or Tox	vn. Steta, Zic	Code)				
ar tree	M. Constance										nia 22206				
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ury or		Cametery, cramatory or other place)   September													
any in	21 Signature of Funeral Service	o Licensee	M0084	Ro 5 75	Name and Ad bert A. 5 57 Wiscon	drass of Faci Pumphrey nsin Ave	Fune enue,	eral Home Bethesda	/Bethesd , Maryla	a-Chevy nd 208	Chase, Inc. 314-3501				
	23a. Partf. Entar tha diseasa,	or raspiratory a	rrast,		Approximata Interval Between										
ysician		or only one output on								1	Onset end Death				
Medical	Immediata Causa (Final diseasa or condition		Subara	chuo	id Hen	norrh	age				6 days				
aminer	resulting in death)	a	Due to (or e					-		1					
E E					i	Years									
physician and s the burial-transit	Sequentially list conditions,														
	Sequentially list conditions, if eny, leading to immediata causa. Entar Undarlying Cause (Disease or Injury that initiated events		1												
s the bu	that initiated events resulting in death) Last		Dua to (or as	a consec	quanca of):					1					
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d for	Part II. Other significant condit	tlone contributing to	death but not resulting	no In the u	inderwing cause	niven in Per	1	23h Did	tohacco uss	contribute t	o the cause of death?				
d by the attend letached for us. Physiclan/	r art ii. Other arginicani condi	Yes 20KN		bably 4 Unknown											
igned i be det by P															
shoul shoul								24a. Was	an autopsy ormed?	av cc	fara autopsy findings vailable prior to omplation of causa daeth?				
5 K									Vac alde						
cartificate has irector, page 2	DE Was acces referred to The	not .		19					Yes 2 No	, 11	☐ Yas 2 No				
is cartificate he director, page To Be Com	25. Was casa rafarred to medic examiner?	Hamitali		10. 1- 11		Other:		th (Chack only		Other (C	4.1				
80	1 Yas 2 No	1 125	•	VOutpatie 3b. Tima o	III JU DON	7	cursing He	ome 5 Rasi 28d. Dascribe			177)				
Afta. fune	1 Neturel 5 □ Pend	ting (Mo	of Injury nth, Day Year)	Injury		njuryat Work? 1 ∐ Yas 2 [	No								
To the Funeral Director: After th completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could	d not be 28e. Plea	e of Injury - At home ding, etc. (Specify)	a, farm, st	reat, factory, offi	ice			'Street and Nu wn, Stete)	mber or Rur	al Route Number,				
C S S															
pletely fill edical		ing Physician: To the il Examiner: On the and ma													
within 24 hours To the Funeral completely fille Medical C	29b. Signatura and title of certif		чл	Jan.		anse number			29d. Data sig		Dey, Year)				
0	0	collecti,				D 460	52		91	26/00	The state of				
	30. Nama and addrass of person Sideral Beck,	who completed cau	usa of death (Itam 2)	Ba) (Type,	Apors	Bethes	dait	40 208	114						
State	31. Deta filed (Month, Day, Yea		Registrar's Signatur	a 4	Ana	No.		77							
Registrar	UCIU	2 2000	11000	p.	jujua										

DHMH 16 Rev 6/95

Francis, Alice alaston 20:45.



State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS: #10E, 26 PER PHY, INFORMANT G789 11-13-0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** October 3, 2000 Irma Corinne Fisher 1235am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fscility Name (If not institution, give street end number) Examiner 812 Crothers La. Rockville Montgomery 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign May 12, 1923 SC 5. Social Security Number **Funeral** 1□M 2 F Days Hours 77 Yrs. 320-22-7505 **Director** Usual Residence of Decedent the Meryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 TNo MD Rockville Montgomery 10e. Street and Number 258 CONCRESSIONAL LANE APT. #103 10f. Zlp Coda 10g. Citizen of What Country? 8 812 Crothers La. ROCKVILLE, MD 20852 20852 United States 23a permit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Heelith and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or hems 29a
page. Funerai 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No if Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify te þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Government Elementary/Secondary (0-12) College (1-4or 5+) Grants Administrator 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Be Lawrence M. Fisher Yoder 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) 13107 Cherub Way, Fredericksburg, VA 22408 Lawrence Fisher Sr./Brother 20b. Place of Disposition (Neme of cemetery, crametory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Buriaf 2 ☐ Cremation 3 ☐ Removal from State Oct 5 Beltsville, MD Chesapeake Crematory 2000 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licenses 22 Name and Addrass of Facility Fapp Funeral & Cremation Services 933 Gist Avenue Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each tine. Approximata Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 3 months Endometrial Cancer Examiner Due to (or as a consequence of) Examiner The lew requires that the death certificate be axecuted use as the burial-tran Sequentially tist conditions, if any, laading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Box 68760, Physician/Medical Due to (or as a consequence of) P.0. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed by of Vital Records, by 90 24b. Were autopsy findings available prior to complation of ceusa of death? 24a. Was an autopsy performed? 2 should Completed certificate hes page 1☐ Yes 2☐No 1 Yes 2 No Hospital or Attending Physician: Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only ona) Other: 4☐ Nursing Home 5☐ Residence (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28c. tnjury at Work? 27. Manner of Death 28a. Date of injury (Month, Day Yeer) 28b. Tima of 28d. Describe how injury occurred After Division 1 Natural 5 Pending investigation s after death. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 281. Location (Straet end Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledga, death occurred at the tima, data and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to the causa(s) and manner stated. edical 29a. Certifier To the 29b. Signature ar 29c. License number 29d. Date signed (Month, Day, Year) D45880 15 03,2000 of person who completed ceusa of death (Item 23a) (Type, Print) Leon Mwang M.D. 10400 Connecticut Ave #606, Kensington, MD 20895 31. Data filed (Month, Day, Year) 32. Registrar's Signature State souks

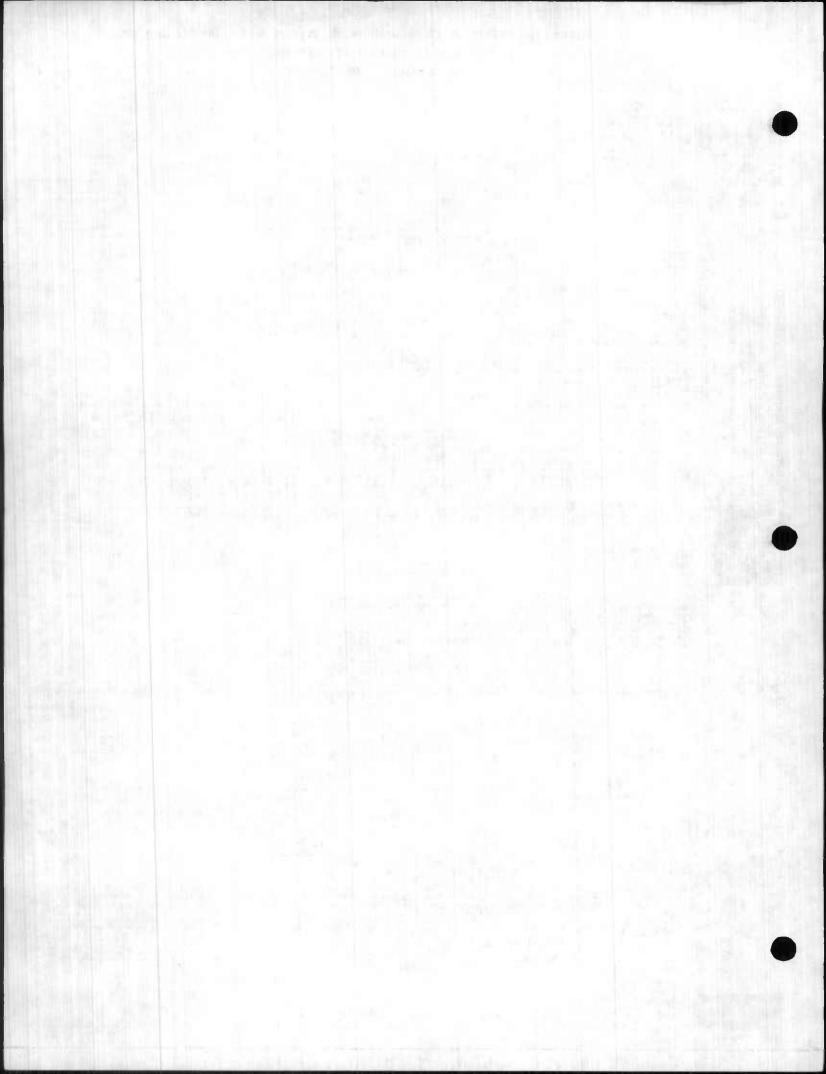
**DHMH 16 Rev 6/95** 

Registrar

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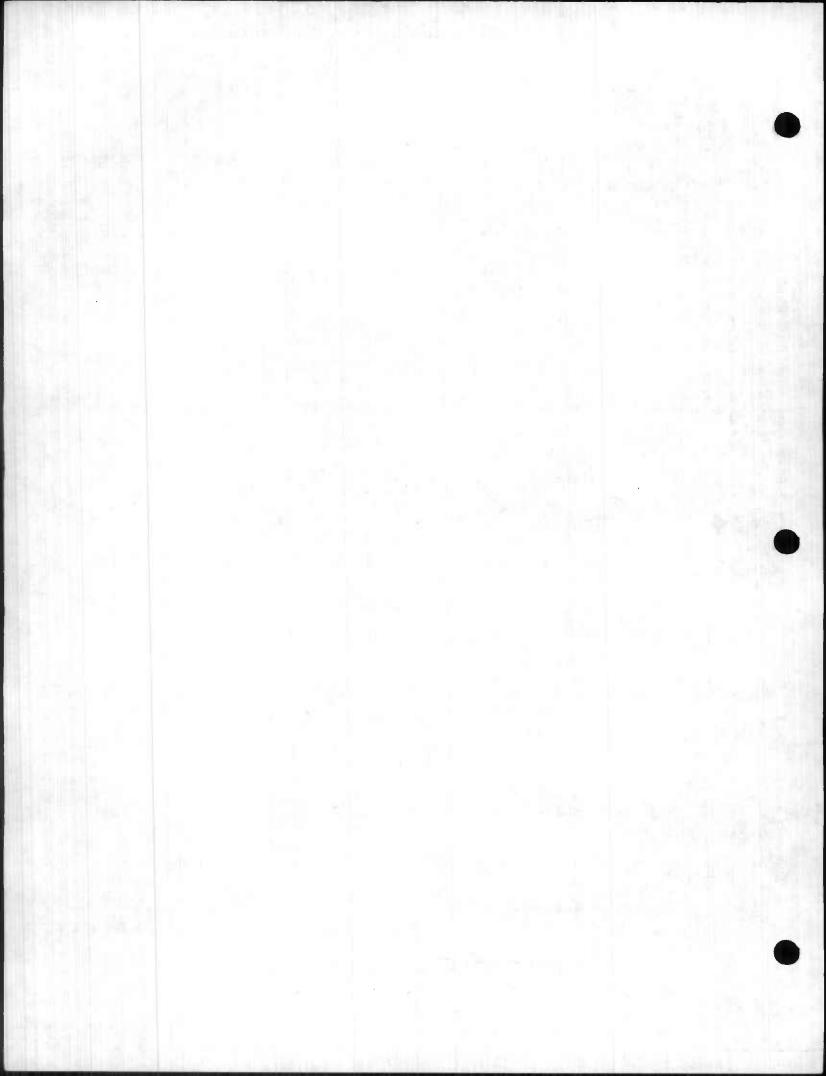
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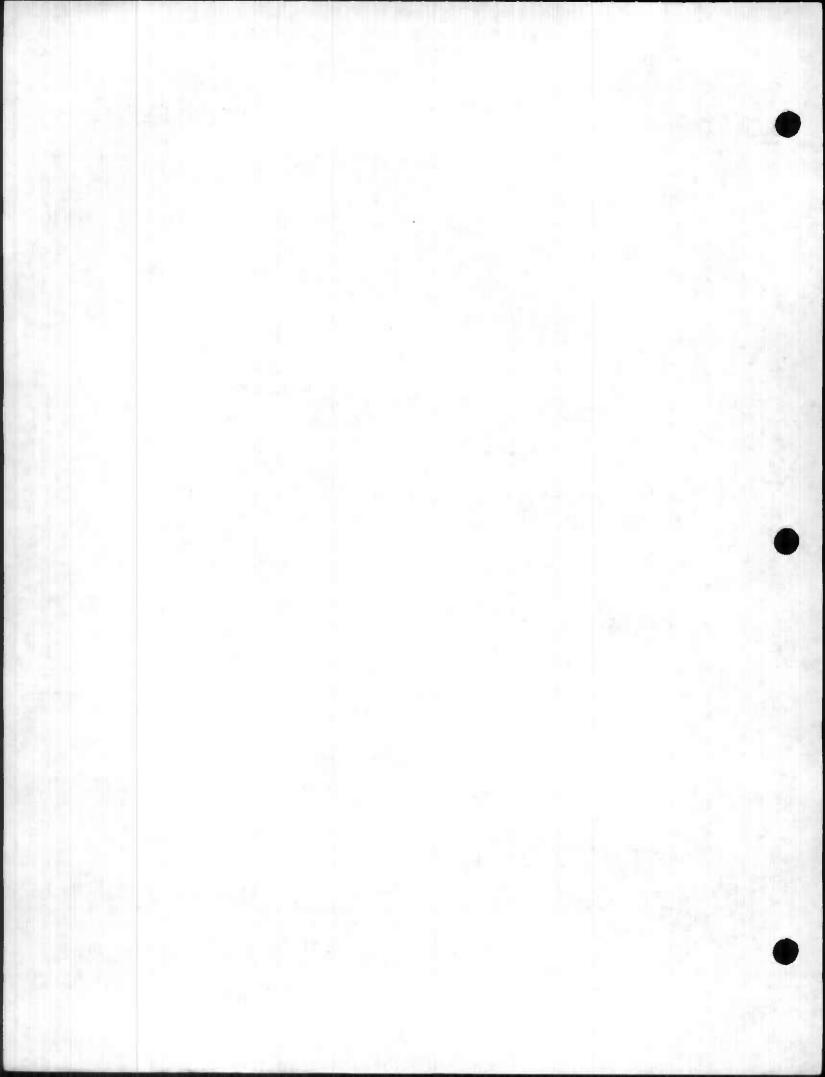
State of Maryland / Department of Health and Mental I	Hygiene	0	0	3	2	7	8	3
Certificate of Death	Peg No							

								Certific	cate of	Death	)		Reg. No.		h- / 1	
	<b>6</b> 1 1 1		1. Decedent's Neme (First, Middle						DEL T			2. Dete of De Month	ath Day	Year	3. Time	of Death
	Physicia /Medica		E. Patricia	Fin	zel								ber 28,		10:	52 am
	Examine	_	4a Facility Name (If not institution	, give	street and num	iber)				4b. City, To	own, or Lo	cation of Deeth	4c. County	of Death		
			Holy Cross Reh		litatio	n an	d Nur	sing C	enter	Burt	onsvi	lle	Montgo			
	Funeral		5. Social Security Number	6. Se	X DM 2KDF		yrs. last bii		Inder 1 Yee oths Deys		Min.	8. Date of Birt (Month, Da		Countr	ry)	or Foreign
	Director	-	219-76-4467 Usual Residence of Decedent				92	115.				Apr 10	, 1908	Maryl	and	
	puel Maria	1	10a. State 10b. County		-1	10c	. City, Tow	n or Location	1					10	d. Inside	City Limits
	Mary	0	Maryland Montg	0.000	2037	c.	i 1,,,,,	Sprin							1 □ Ye	s 2 No
	the post	X h	10e. Street and Number	One	Ly		TIVEL	_	f. Zip Code				10g. Citizen of V	Whel Countr	ry?	
	3 on or		1912 Brisbane S	tro	o.t			2	0902				USA			
	72 hours after death with the Maryland natural; or frams 23s or 28s-f show acet Examinar must be notified at	S -	11. Merital Status		12. Was Dece	dent Ever	in U,S.			Hispanic Or	rigin? (Spe	cify Yes or No Rican, etc.)		e - America		
0	or he		1 ☐ Never Married 2 ☐ Marr	ied	Armed For	2X No			es 2 XNo			nican, etc.)		ck, White, et		
02	ours.	2	3 ☐XWidowed 4 ☐ Divorced		If Yes, Give Yeer or Da	tes:		101	B2 5 TVA	Specify			Specify	Whit	e	
2	"natural",	Completed	15. Deceden (Specify only highes	's Edu	le completed)		16a	. Decedent's (Give kind of life. DO No	Usual Occu	pation during mos	st of working	ng	16b. Kind of B	usiness/Indu	ustry	
12	within ene.	2	Elementery/Secondery (0-12)	Ť	College (1-	4or 5+)	<b>—</b>			ed)						
Maryland 21215-0020	o filed v	3	17. Father's Neme (First, Middle,	f act)	2		Но	memake	r	10 Moth	or's Name	/First Middle	Own Hon Maiden Sumen	-		
and		Ď								*				16)		
2	should by nd Mente marked umetic ev	2	Robert John Rug		no Drint		401	Addition Ast	dana (Cara			Schreil	oer or, City or Town,	State Tim !	Codel	
Ma	han han r la r		19e. Informant's Name/Relations													
	Healt Ther	-	Robert P. Finze	I_/	Son	20	b. Place 0	13/U B Disposition ry, crematory	(Name of	e Roa	d, Si	lver S	oring, N		m State	
2	permit. Pages 1 and 2 should b Department of Health and Mente Important: If Item 27 Is marked any Injury or other traumatic e page.		1 ☑ Burial 2 ☐ Cremation			1818					1					
Baltimore,	rtant njuny	-	4 □ Donetion 5 □ Other (S <sub>1</sub> 21. Signature of Funeral Service			1	ot. J	ohn's		ery ess of Fecil		0/2/00	Silver	Sprin	g, M	עו
Ba	Deparimpor		21. Signature of Funeral Service	Licens	00	11		Franc	cis J.	Col1	ins I	Funeral	Home,	Inc.		
_		_	footly	16	mel	h		500 t	Jniver	sity	Blvd.	, W, S	ilver S			
93		4	23a Pert1. Enter the disease, or shock, or heart failure. List	complionly of	lications that ca ne cause on ea	used the o	deeth. Do	not enter the	mode of dy	ring, such as	s cardiac o	r respiretory e	rrest,		Approxim Interval B Onset an	Between
	Physician /Medical		Immediate Cause (Final												Diriset air	o Dealii
	Examiner		disease or condition		a Leuk	emia								1	yea	r
	100	- E	resulting In death)  Due to (or es e consequenca of):													
	nsit	E Sequentielly list conditions.  Due to (or as a consequence of):												i		
,	icate be executed physician end s the burial-transit	EXB	if any, leading to immediate cause. Enter Underlying													
68760,	sicia bur	Cause (Disease or injury C. Dise to for as a consequence of):														
9		Ned	resulting in deeth) Lasi			500	(0. 45 4	00.1004001100								
Вох	andin use	2		•	d											
	death e atter	SICIE	Part II. Other significant condition	ns cor	ntributing to dea	ath but not	resulting i	n the underly	ing cause g	iven in Pert	1.	23b. Dld	tobacco uee co	ntribute to	the caue	e of death?
P.0.	requires that the death cer een signed by the attendir hould be detached for use	Physician/N	II 4.1 4.1-4									10	Yss 2X No	3 Prob	ably 4	Unknown
	gned be de	2	Hypothyroidism	-						-						
Records,	been si should	Del										24a. Was perfo	an autopsy rmed?	avai	ilable pric	y findings or to
ပ္ပ	% & & & & & & & & & & & & & & & & & & &	Completed					-							of d	pletion o	or cause
	The late h	0										10	Yes 2 No	1 🗆	Yes 2	₩ No
Vital	slan: entifica ector,		25. Wes case referred to medical exeminer?								e of Death	(Check only	one)			
	Physician: this certific ral director,	0	1 Yes 2 No	1	Hospitel: 1 ☐ In	patient	2 ER/O	ulpatient 3[	DOA	ther: 4X N	lursing Hor	ne 5 Resi	denca 6 🗆 Oth	er (Specify)	)	
0	ng Pt ter th	5	27. Manner of Death 1 ☑Neturel 5 ☐ Pendin	a	28a. Dete of (Month)	Injury Day Yea	28b.	Time of Injury	28c. Inj			28d. Describe	how injury occur	red		
Division of	Attending in deeth.	180	2 ☐ Accident investig	elion				М	10	Yes 2	] No					
Ë	rect rect n by	Certification:	3 ☐ Suicide 6 ☐ Could redeterm	ined	28e. Place o	of Injury - I g, etc. (Sp	At home, fa ecify)	arm, streel, fa	ctory, office	•	3	28f. Location ( City or To	Street and Numb vn, State)	er or Rure!	Route No	umber,
	ral Delli															
	Hoep 14 hoe Fune tely fi	edical	(Check only 2 Medical !	g Phy Exami	ner: On the bas	sis of exan	knowledge nination an	e, death occu d/or investig	rred at the setton, in my	time, dete a opinion, de	nd plece, a ath occurre	and due to the ed et the time,	cause(s) and ma date and place,	and due to	the cause	e(s)
	To the Hospital or Attending Physician: The is within 24 hours after deeth.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page		one) 29b. Signature and title of contilion		and mann	er steted.		0. 1	29c. Licer	nse number			29d. Date signe	d (Month, f	Day, Year	7)
	₩ ¥ 5 8		255. Orginator and the organization			/		)								
	25		0	-		1		ND	D 05	3528			Septemb	er 29	, 20	00
			30. Name and address of person						- 1 11	h = = + :	- MD					
	CARA		Daphna Henkin 31. Date filed (Month, Day, Year)	, M		9 Sno		eld Ro	1		II, MD					
	State Registra	-	OCT 0 2	20		que		9. 16	pork	2						



State of Maryland / Department of Health and Mental Hygiene 00 32789

				Ce	rtificate o	f Death	7	1	Reg. No.					
Physician	Decedent's Name (First, Middle		ephine	V. Feu	ıry			2. Date of Dec Month		Yeer 2000	3. Time of Death 7:15 AM			
/Medical Examiner	4a Facility Neme (If not Institution	give street and num	n <i>ber</i> )			4b. City, To	own, or Lo	cation of Deeth			7:13 AM			
Examine:	Potomac Valle	y Nursing	Home			Rock	cvill	e	Mont	gomer	У			
Funeral Director	5. Social Security Number 090-05-5747	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. 85	last birthday) Yrs.	Months Day		Min.	8. Date of Birt (Month, Day August 6	, Year) , 1915	9. Birthp Coun New	lace (State or Foreig try) York			
	Usuel Residenca of Decedent													
or hems 23s or 28e-f show knicer must be notified at y Funeral Director	Maryland Montg	omery		ty, Town or Lo lethesd						1	0d. Inside City Limit 1 ☐ Yes 2 ី N			
or the full be notified	10e. Street and Number				10f. Zip Code				log. Citizen of What Country?					
aga aga	4830 Montgomer	y Lane			208	314		5 (	United	State	es			
r heme 23. siner.must Funeral	11. Marital Status	12. Wes Dece Armed Fo	edent Ever in U	,S. 13.	Was Decedent o	f Hispanic Or	rigin? (Spe	cify Yes or No-		e - Americ				
2 E	1 Never Merried 2 Merri 3 Widowed 4 Divorced		2 <b>∑</b> No ⁄e		1□Yes 2X N				Specify	· ·	ite			
ygiene, wer than "natur it, the Medical Completed	15. Decedent	s Education		16a. Dece	dent's Usual Occ	upetion	et of worki	na	16b. Kind of B	usiness/Ind	lustry			
o un old	(Specify only highes Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	kind of work dor DO NOT use reti	ired)	St OF WORK	ng .						
ort, the	12			Pay	roll Cle	erk			Adve	rtisi	ng			
5 5	17. Father's Name (First, Middle,	ast)				18. Moth	er's Name	(First, Middle,	Maiden Suman	ne)				
To F	John Edward H	eury				Man	ry T.	McGone	ga1					
E E	19a. Informant's Name/Relational Regina T. Rich		e		ng Address (Stree						Code) 20814			
other tr	20a. Method of Disposition		20b. I	Place of Dispo	osition (Neme of			Dete			wn, State			
reportant: If Nem 27 ny injury or other to nice.	1 M Buriai 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify)   Gate of Heaven Cemetery 2, 2000 Hawthorne, New Y													
any in	1 M Buriai 2 Cremation 3 Removel from State cemetery, cremetory or other placa)													
	23a. Pert1. Enter the diseese, or	complication hat c	aused the deel	th. Do not en	ter the mode of o	lying, such es	s cardiac o	r respiretory a	rest,		Approximete			
ial-transit	resulting in death)  Due to (or as a consequence of):  Pneumonia  Bue to (or as a consequence of):  If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):  Due to (or as a consequence of):													
ing physicia e as the bur Medical	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as e consequence of):													
Q 20	Part II. Other significant condition	se contributing to de	ath but not see	ulting in the	indertring sauce	chien in Part		23h Did	Iohacco use co	ntribute to	the cause of deat			
detached detached		is contributing to de	satil but not les	salang in are c	moonying cause	giveri in r an					bably 4 Unknow			
y Pet y	Dementia								100 120 110					
sate has been signed, page 2 should be del Completed by P								24a. Wes perfo	an autopsy rmed?	av co	ere autopsy findings allable prior to mpletion of cause death?			
Comp									Yes 210 No		Yes 2□ No			
rector, pa	00.14						15	10		11	Tes ZU NO			
rector.	25. Was case referred to medical axaminer?	Hospital:				Othor		(Check only o						
P F	1 Yes 2 No 27. Manner of Death	101		ER/Outpatie	nt 3LI DOA	4 (4(1)	-		denca 6 Otl		ý)			
ed in by the funeral Certification:	1 Natural 5 Pendin investig	ation	of Injury th, Dey Year)	Injury		njury at Vork? Yes 2	] No							
d in by t	3 Suicide 6 Could r 4 Homicide determ	208. PIECE	of Injury - At h	ome, farm, st	reet, factory, offic	Ce .		28f. Location (- City or To		ber or Ruri	al Route Number,			
To the Funeral Dir completely filled in Medical Cerl														
Med Med	29b. Signeture and title of certifier	and man	nor states.	-	29c. Lice	ense number			29d. Date signe	ed (Month,	Dey, Year)			
1 .	VI mila	44 000	11		1 D3	35791			Senter	ber '	28, 2000			
10	11100	XY	ruy						Dopcen		2000			
	30. Name and address of person							17.6			00000			
	Merlyn K. Vemury, M.D., 9801 Georgia Avenue #227, Silver Spring, Maryland 20902							20902						
State	31. Dete filed (Month, Day, Year)		gistrer's Sign	eture 4	Span	es								
Registrar	OCT 0 2	2000		/	//									

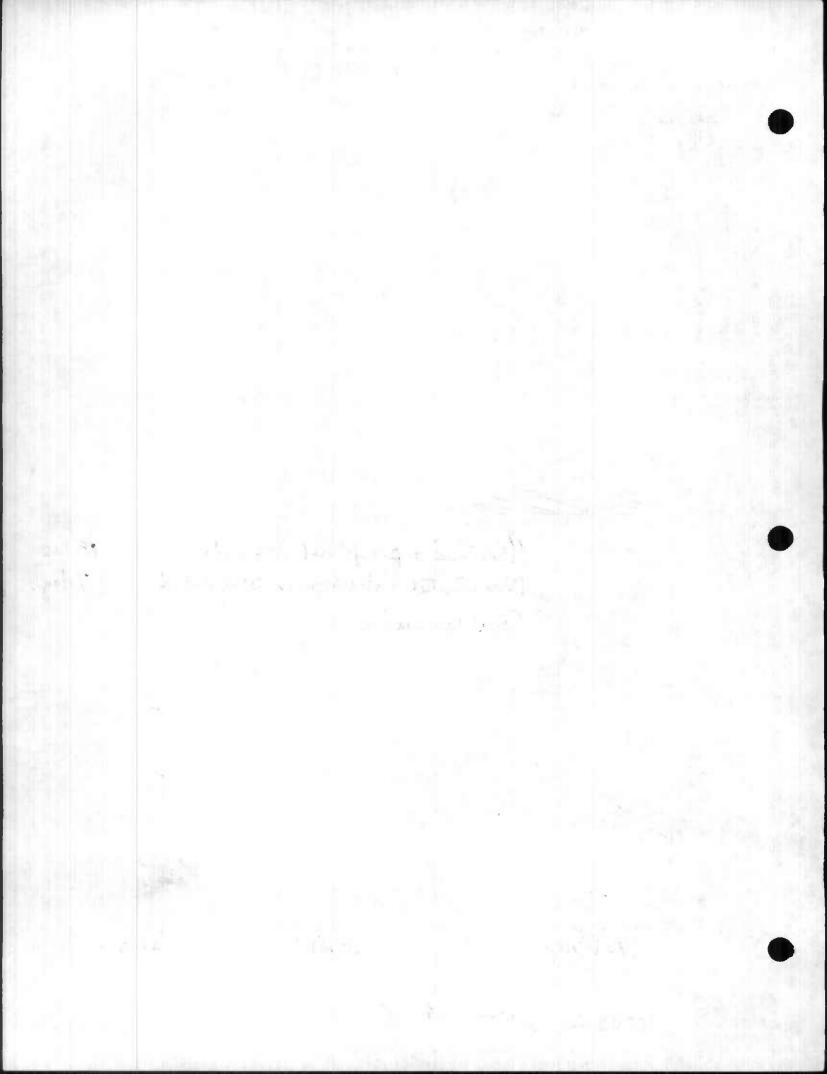


State of Maryland / Department of Health and Mental Hygiene 0 0 32790

Certificate of Death

Reg. No.

					C	ertifica	e or i	Dealn			Reg. No.		
aucician	1. Decedent's Name (Fire	st, Middle, Las	t)							2. Date of De Month	Day	Year	3. Time of Deal
nysician Medical	Garfield	Will	iam (	Green,	Jr.					SEPT	28	2000	0255
xaminer	4a Facility Name (If not i	institution, give	street and nu	mber)			4	b. City, To	wn, or Lo	cation of Deat	h 4c. Cou	nty of Death	
	The	Memor	ial Ho	spit	al			East			T	albot	
neral	5. Social Security Number		M 2DF	7. Age (In ye	s. last birthde	y) If Unde Months	r 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birthp	lace (State or For
ector	216-40-423	34	MM 2UF	56	Yrs.		,-			Aug.31		Mary:	
	Usual Residence of Dece 10a. State 10b.	. County		100 (	City, Town or	Location						1	0d. Inside City Lir
rector				100.									1 Serves 2
cto	Maryland	Talbot			St.Mi	chaels		115					
Director	10e. Street and Number					10f. Zi	Code				10g. Citizen	of What Coun	itry?
<u> </u>	307 Dodso	on Ave.					.663				USA		
Funeral	11. Marital Status		12. Was Deci	rces?	U,S. 1	<ol> <li>Was Dece If Yes, spe</li> </ol>	dent of H	ispanic Orig In, Mexican	gin? (Spe , Puerto	ecify Yas or No Rican, etc.)	)- 14. F	lace - Americ lack, White,	
by Fi	1 Never Married		1 ☐ Yes If Yes, Gir	2 No		1□ Yes	20 No	Specify:			Spe	cify:	
	3 ☐ Widowed 4 ☐ I		Year or D	ates:								В.	lack
Be Completed	15. f (Specify on	Decedent's Ed	de completed)		16a. De (Gi	cedent's Usi ve kind of wi . DO NOT	al Occupi ork done o	ation du <i>ring most</i>	of work	ing	16b. Kind of	Business/Ind	dustry
Idm	Elementary/Secondary	(0-12)	College (	1-4or 5+)				1)					
ပိ	11	100000			Crew	Leade	r	40 Maria	da Atama	/f**:		c Wor	ks
Be	17. Father's Name (First,	MIODIE, Last)						18. Mothe	r's Name	(First, Middle	, Maiden Sum	ame)	
2		W. Gre							rrie		e Cool	-	
	19a. Informant's Name/F	Relationship (7	ype, Print)		19b. Ma	iling Addres	s (Street	and Numbe	or Aur	al Route Numb	er, City or Tox	vn, State, Zip	Code)
once. To Be Co	Sharon Sta		n /wife					St.Mi	chae	ls, Mar			
	20a. Method of Disposition		Domovel from		. Place of Dis	position (Na rematory or	me of other plac	ce)	1	Date	20c. Locatio	n - City or To	wn, State
	4 Donation 5				Bryran	U.M.	Chur	ch Cer	m. 1	0/2/200	00 Gras	onvil1	e,Maryl
#	21. Signature of Funeral	Service Licen	100			22. Name a				-11	0100		
DUCE	1	2	_	-		Benr	ie S	mith	Fune	ral Ho	me	21601	
	234 Part1. Enter the dis	sease, or comp	lications that o	aused the de	eth. Do not							21001	Approximate
an	shock, or heart faile	ure. List only o	ne cause on e	ach line.									Onset and Dea
ai	Immediate Ceuse (Final		Mes	outos.	·	nosi	show	11	tole	4110		100	18 luc
er	disease or condition resulting in death)		a. / [-03		(or as a con	my	,,		,			1	,
je la			n.ke	0 44	Ticl	Lu V	Valo	Lan	9	ragul	atur	1	7 day
edicai Examiner	Cognectially list condition		b	Due to	(or as a cons					-			
EX	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury	iate	Colo		velu								
Cai	that initiated events		c. Cerc	-	(or as a cons	-							
2	resulting in death) Last	575											
hed for use as the burial-transit /sician/Medical Examit			d										
by Physicia	Part II. Other significant	conditions co	ntributing to de	ath but not r	esulting in the	underlyinn	rause niv	en in Pert I		23b. Did	tobacco usa	contribute to	the cause of d
by Physician	outer arginicant	O STIGITION & CC		Dat not 1	oouning in the	chaonyng	orneo Ala	Service OILL			Yes 2 11	_	bably 4 Un
× ×						_							,
should be											an autopsy	24b. W	ere eutopsy find
Completed										perf	ormed?	CO	allable prior to impletion of cau death?
0.										15	Yes 2 No	-	
												11.	JYes 2□No
	OF Menance August	+	Hospital:	/		–	Oth Oth	er.		h (Check only			
Be Co	25. Was case referred to examiner?		1 LIP		☐ ER/Outpat 28b. Time		OA	4 L NU	-	me 5 Res 28d. Describe			(y)
To Be	examiner? 1 ☐ Yes 2 ☐ No		Zoa. Date	of Injury th, Day Year)	lnjur		28c. Injur Wor			Lou. Describe	injury oc	331100	
To Be	examiner? 1 Yes 2 No  27. Manner of Deeth 1 Natural 5	Pending	(NOI)			8.4		Vac all					
To Be	examiner? 1 Yes 2 No  27. Manner of Deeth 1 Natural 5 2 Accident	investigetion Could not be		at latina	home to	M desta		Yes 2 🔲	No	28f Loopties	(Stragt and th	mher or D	al Bouto Alumba
To Be	examiner? 1 Yes 2 No  27. Manner of Deeth 1 Natural 5 C	investigetion		of Injury - At	home, farm,			Yes 2	No	28f. Location City or To	(Street and Nu wn, State)	mber or Rur	al Route Number
Certification: To Be Co	examiner?    Yes 2   No   No   No   No	investigation Could not be determined	28e. Place buildi			street, facto	y, offica			City or To	wn, State)		
ical Certification: To Be Co	examiner?  1 Yes 2 No  27. Manner of Deeth 1 Natural 5 2 Accident 3 Suicide 6 4 Homicide	investigetion Could not be	28e. Place buildi relcian: To the iner: On the b	best of my k	nowledge, de	street, facto	ry, offica	ne, date an	d placa,	City or To	wn, State)	menner as s	al Route Number
ledical Certification: To Be Co	examiner?  1 Yes 2 No  27. Manner of Deeth  1 Natural 5 Cacident  2 Accident  3 Suicide 6 Cacident  4 Homicide  29a. Certifier (Check only one)	investigetion Could not be determined Certifying Phy Medical Exam	28e. Place buildi relcian: To the iner: On the b	best of my k	nowledge, de	street, facto	y, offica Lat the tin n, in my o	ne, date an pinion, dea	d placa,	City or To	wn, State) cause(s) end date end ple	menner as s ce, and due to	stated. o the cause(s)
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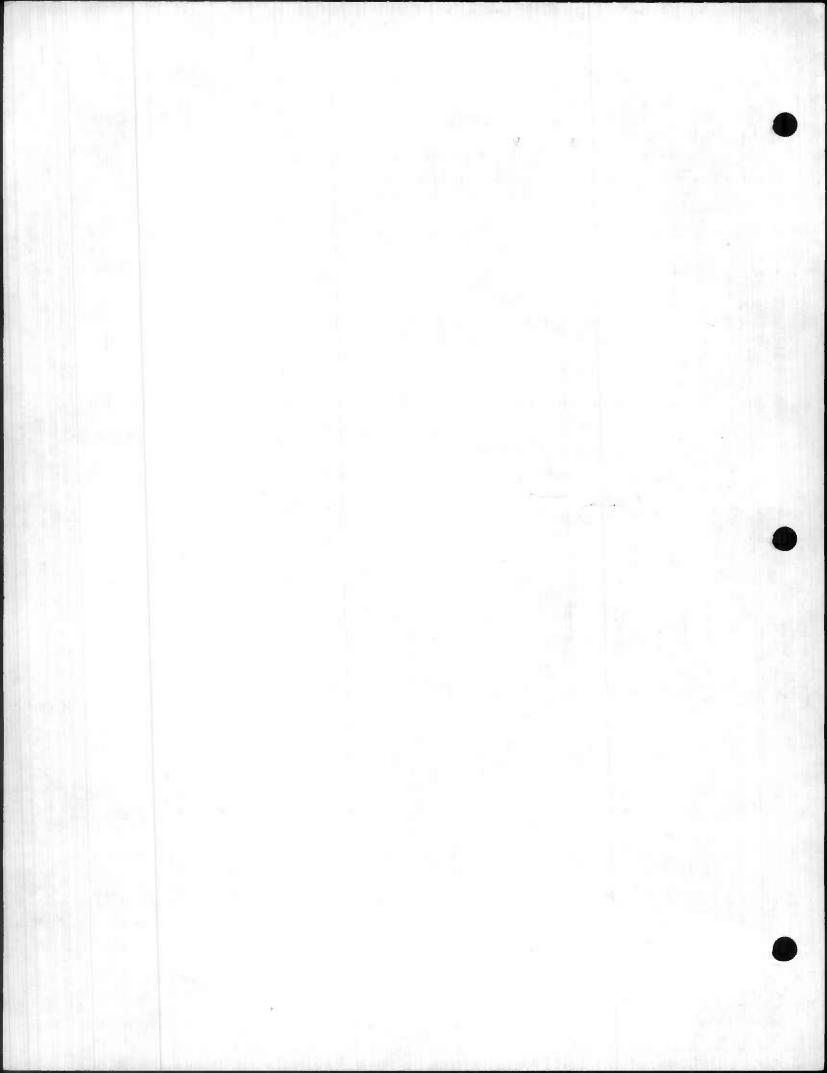


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month SEPT. **Physician** 27, 2000 5:00 AM GRUPP BETTY /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14613 MOCKINGBIRD DRIVE DARNESTOWN MONTGOMERY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 GERMANY 8. Date of Birth (Month, Day, Year) MAY 26, 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 KF Days Hours Months Yrs. 1912 066-01-0741 88 Director **Usual Residence of Decedent** with the Maryland 10b. County 10c. City, Town or Location 10d. tnside City Limits show me 23s or 28s-f show must be notified at 1K Yes 2 No Director MONTGOMERY DARNESTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? e filed within 72 hours after death with al Hygiene, other than "natural", or leans 23s or vent, the Medical Examiner must be a 20874 USA 14613 MOCKINGBIRD DRIVE Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 ₩idowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event abos. 88 Lo LASKA FRANKEL MOSHE KATZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14613 MOCKINGBIRD DRIVE, DARNESTOWN, MD 20874 MARION WICKER / DAUGHTER 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) 19/29/00 MISSION HILLS, CA EDEN MEMORIAL PARK 21. Signature of Funeral Service tipenses 22. Name and Address of Facilit DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical w2ocardial Infarction Examine Examiner pertension attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. acema 1(6 A Physician/Medical Due to (or as a consequence of): Syndiame Sinn C aigned by the ai P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ernentia. Records, by 24b. Were eutopsy findings available prior to been ai 24a. Was an autopsy performed? Completed completion of cause of death? his certificate has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 | Inpatient 2 | ER/Outpetient 3 | DOA 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation Naturat 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier na Coup D41162 100 9/27/00 30. Name and aduless of person who completed cause of death (Item 23a) (Type, Print) 19529 DOCTOR'S DRIVE, GERMANTOWN, MD 20874 VINU GANTI, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 04 2000 DERECER oaker Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗍 🗍 Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Nema (First, Middla, Last) **Physician** SEPTEMBER 29, 2000 10:55 PM SAMUEL W. GREENHOUSE /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Nema (If not institution, give street and number) Examiner MONTGOMERY 11705 MAGRUDER LANE ROCKVILLE If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplece (Stete or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** Months Deys Hours Min 1♥M 2□F 82 Yrs. NEW YORK Director 050-14-5389 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County i Hygani obsertien 'netural', or herra 22a or 22a-f show went, the Medical Examiner must be notified at 1 ☐ Yes 2V No Director ROCKVILLE MD MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 U.S.A. 5802 NICHOLSON LANE #608 Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Bleck, White, etc. 11. Merital Status 1 X Yes 2 No If Yes, Give Year or Detes: WII 1 ☐ Never Married 2 ☐ Merried Specify: WHITE Saltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: à 3 XWidowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) UNIVERSITY STATISTICIAN 5+ 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be 2 should be and Mental H is marked LENA RUBIN JOSEPH GREENHOUSE 2 gest 1 and 2 sho reatment of Health and M Important. If Iem 27 is mark any Injury or other 1 2058. 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6460 WINDERMERE CIRCLE, ROCKVILLE, MARYLAND 20852 RICHARD GREENHOUSE/SON 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition OCT 2, 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 2000 ADELPHI, MARYLAND LEBANON CEMETERY 21. Signeture of Funaral Ser Licansee 22. Name end Address of Fecility EDWARD SAGEL FUNERAL DIRECTION, INC. 20852 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onsat and Deeth **Physician** Immedieta Ceusa (Final disease or condition resulting in deeth) /Medical ESOPHAGEAL CANCER ONE YEAR Examiner Due to (or es e consequence of) Examin ician and burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in deeth) Lest Due to (or es e consequence of) be axec the attending physician Box 68760 Physician/Medical Dua to (or es e consequença of) as the 950 Jo Pert ft. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? PO detached 1 Yes 2 No 3 Probably 4 Unknown yd bengis CONGESTIVE HEART FAILURE þ Records, 8 24b. Were eutopsy findings evailable prior to complation of causa ot deeth? 24a. Wes en autopsy performed? Completed peen page 2 certificate has 20XNo 1 Yas 1 ☐ Yes 2 ☐ No of Vital Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) DAUGHTER'S Hospital: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) RESIDENCE 0 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Certification: is or Attending Parties after death.

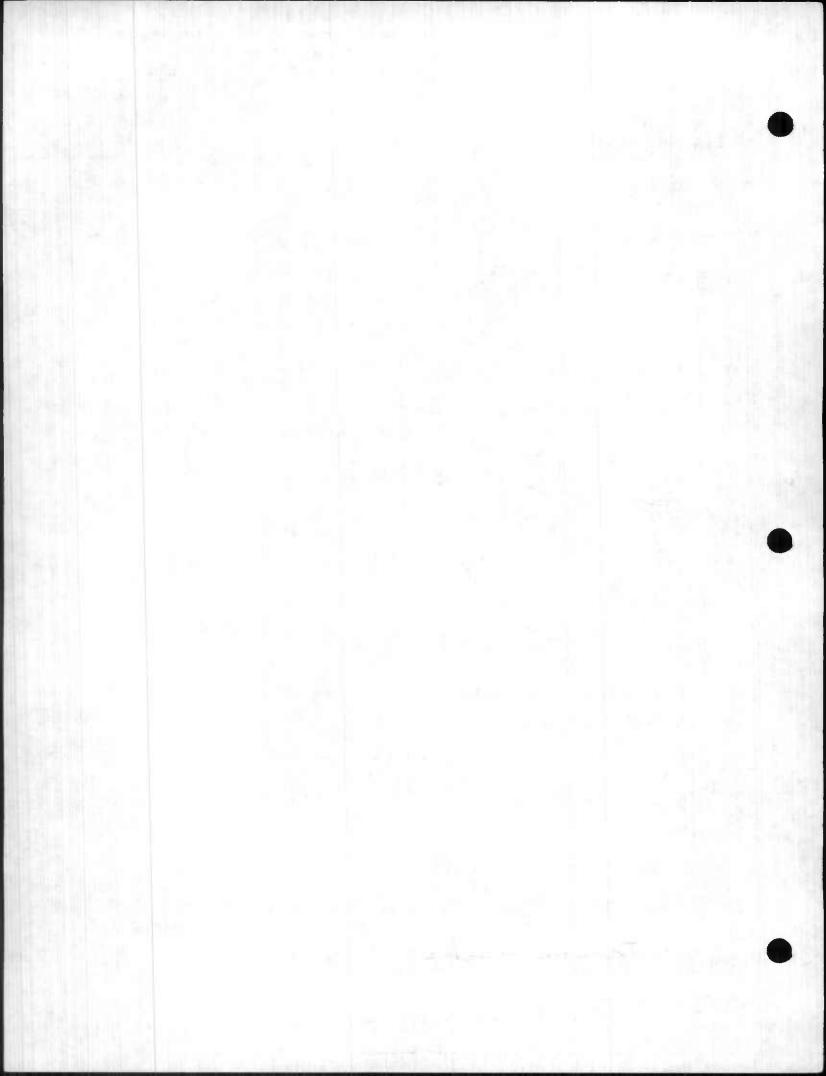
I Director: After it in by the funera Division 5 Panding Investigation 1 X Neturel Injury 1 Yas 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homiclde To the Hospital of within 24 hours a. To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edicai 29a. Certifier completely 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number OCTOBER 1, 2000 MD12568 Sacks

State Registrar 31. Dete filed (Month, Day, Year)
OCT 6 3 2000

DR. THOMAS SACKS, 2021 K STREET, NW, WASHINGTON, D.C. 32. Registrar's Signeture

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #23a,10/5/2000, BMW, Montg. Co. Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** HENRY GREEN 30, SEPT. 2000 1630 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gladys Spellman Nursing Center Cheverly PRINCE GEORGES If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours XIM 2DF Yrs. 249-46-4715 67 Director Apr. 29, 1933 S. Carolina Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits 28a-f show 1 Ves 2 No Director Frederick MD Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 457 W. South Street 21701 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status filed within 72 hours after 1 X Yes 2 No If Yes, Give 1 Never Merried 2 Married b 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th Heavy Equipment Operator Construction Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H tant: If Rem 27 is marked off lury or other traumatic ever Be Hostan Green Hattie Keckley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvette Green-Ragland (Dau.) 457 W. South St., Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State TE Buriel 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat'l Cem 10/10/00 Ft. Myer, VA 5 Other (Specify) 22. Name and Address of Fecility
SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses ROCKVILLE, MD 20850 e, or complications, hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one causion each line. 23a. Pert1. Enter the disease shock, or heart failuit Approximate tntervel Between Onset and Degree Physician Immediate Cause (Finat disease or condition resulting In death) /Medical Examiner Examiner Intracerebral Hemorrhage 110110 The law requires that the death certificate be executed pue Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the Due to (or as e consequence of): 080 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. 3 Probably 4 ☐ Unknown 1 | Yes 2 | No Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No this 28e. Date of Injury (Month, Day Year) 27. Menne of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending death. 1 TYes 2 No investigetion 2 Accident To the Hospital or Attended within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai completely (Check only one) 29b. Signature and title of contain 29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

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30. Nama and address of person who completed cause of death (flem 23a) (Type, Print)

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32. Registrar's Signature

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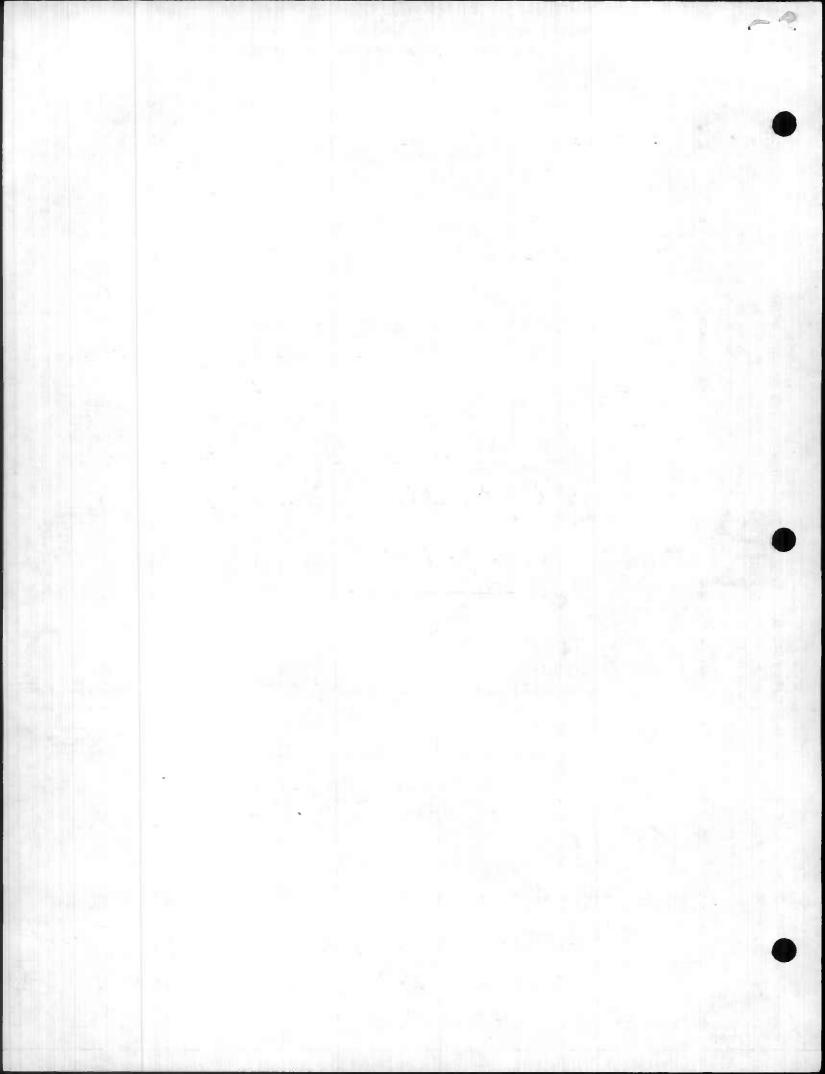
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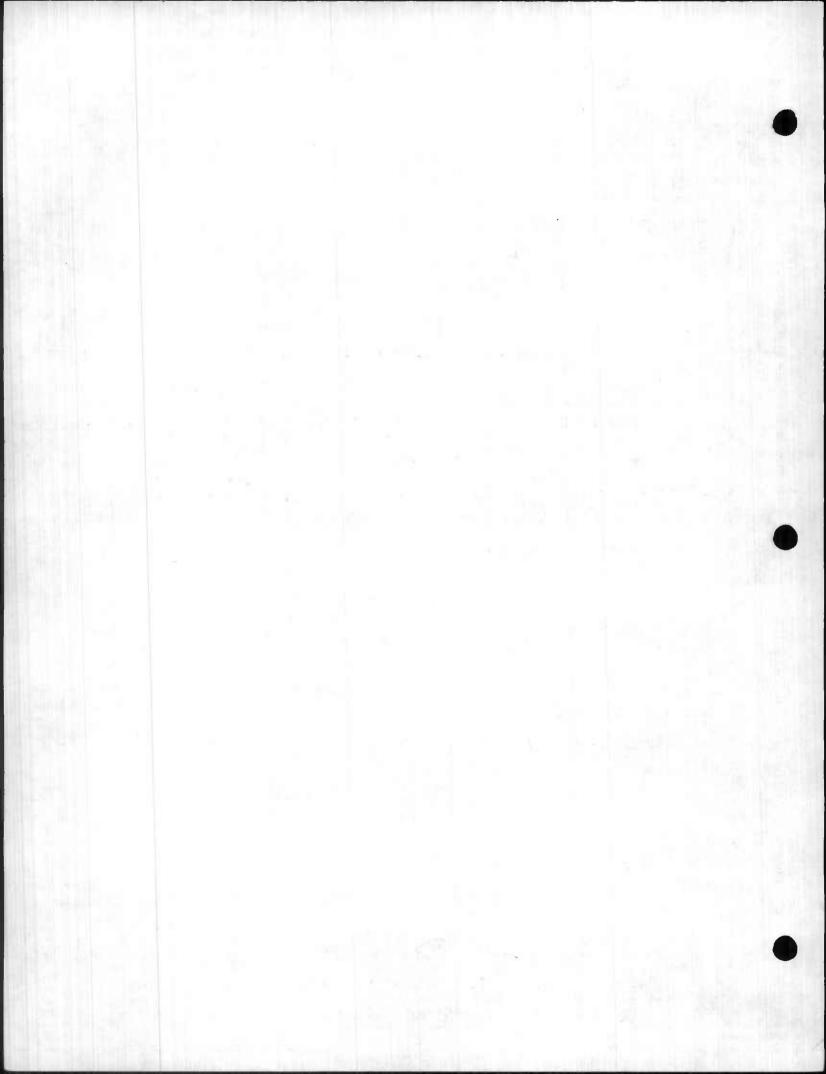
31. Date filed (Month, Day, Year)

OCT



State of Maryland / Department of Health and Mental Hygiene

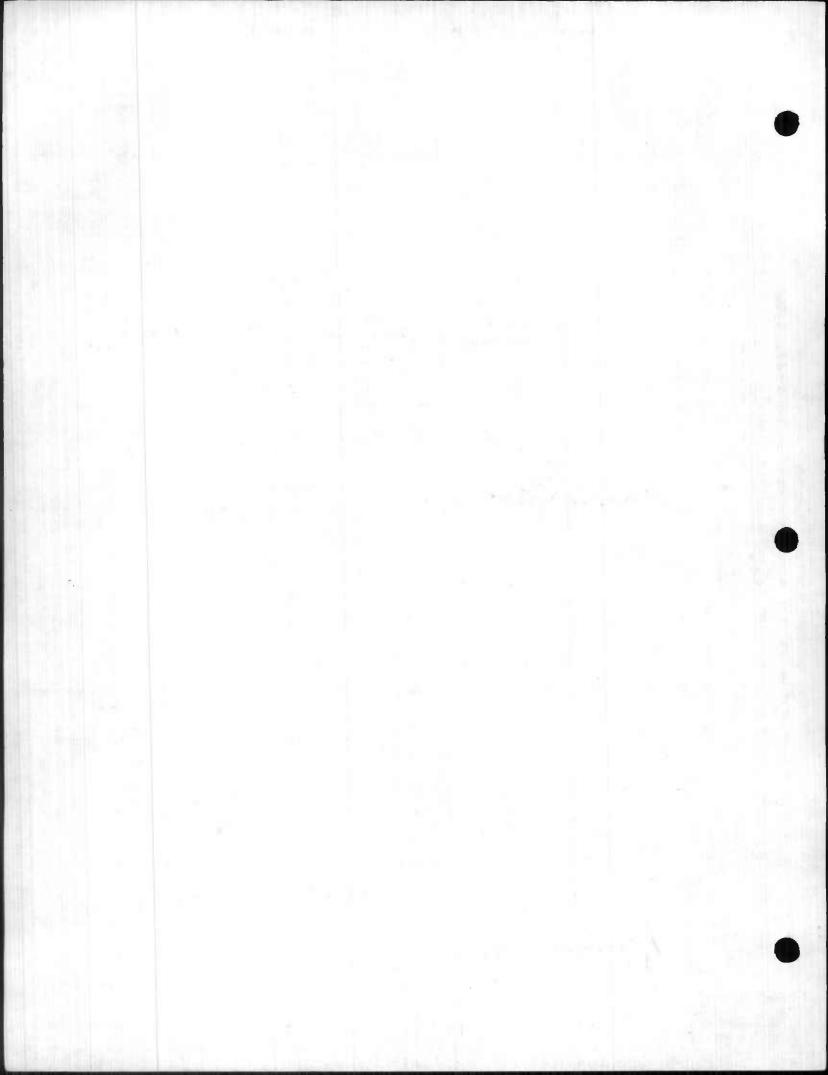
					Certifica		Death		g. No.	3	2/94
100	Physician	Decedent's Nama (First, Middle, La.						2. Data of Deat Month		Year	3. Tima of Death
	/Medical	LILLIAN	IRENE	GRA	NT			OCTOBER	3, 200	0	6:50 AM
	Examiner	4a Facility Nama (If not institution, giv	e street and number)			4	lb. City, Town, or L	ocation of Death	4c. County o	d Death	
		419 RUSSELL AVENU	E, #214				GAITHERS		MONTG	OME	RY
	Funeral Director	5. Social Security Number 6. S 019-10-8003	Sex 7. Ag	79	Yrs. If Under Months	or 1 Year Days	If Under 24 Hrs. Hours Min,	8. Data of Birth (Month, Day, NOV . 25	Year) 1920 M	Cour	Nace (State or Foreign htry) ACHUSETTS
	er death with the Maryland Herns 23s or 23s-f show ner mast be notified at Universit Director	10a. Steta 10b. County		10c. City, Town						1	0d. Inside City Limits 1X Yas 2 No
	or 28a-1 se notifie	Maryland Montgon	nery	Gaithe	ersburg	ip Code		140	ng. Citizen of Wi	hat Cause	10.0
	Milbar II Dir	419 Russell Avenu	o #214			0877			nited S		
	her death r hems 23 kiner must Furneral	11. Marital Status	12. Was Decedent I	Evar in U,S.			lispanic Origin? (Sp an, Mexican, Puerto		14. Race	- Americ	an Indian,
Maryland 21215-0020	ar, or he Examine by Fu	1☑ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced	Armed Forcas? 1 ☐ Yas 2 XXI If Yas, Giva Year or Dates:	ło	If Yas, sp		nn, Mexican, Puerto Specify:	Rican, etc.)	Specify:	, Whita, Whi	
2	naturalization of 27 ho	15. Decedent's Ed (Specify only highest gra	ducation	16a.	Decedent's Us	uat Occup	ation	ina	16b. Kind of Bus	iness/Inc	dustry
2	men de	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT	use retired	during most of work d)	any .			
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nd	Be seem	17. Fathar's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle, M	faiden Sumame	)	
yla	Ment Ment Mic To	Levi Grant					Irene Ga	rdiner C	орр		1-1-y-11-11
ar	and and	19a. tnformant's Name/Reletionship (	Type, Print)	19b	. Meiling Addres	ss (Street	and Number or Rui	ral Route Number,	City or Town, S	state, Zip	Code)
	K Health and I have the stress of the contract	Betty Stevens (Fr	iend)				venue #21				
ore	1 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20a. Method of Disposition  1 Burial 2 Cremation 3 D	Removal from State	20b. Place of cemeter	Disposition (Na ry, cremetory or	ame of other plac	xe)	Data 2	20c. Location - C	City or To	own, Stata
E	Pages ment of ant: It is ury or o	4 Donation 5 Other (Specific		Metrop	olitan	Crema	atory 1	0/3/00 A	lexandr	ia,	Virginia
Baltimore,	Depart Depart Import any in	21. Signature of Funarat Sarvice Lie	DeVICI	/			ss of Facility  Park Dr.	DeVol Fo			20877
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	/Medical	Immediata Causa (Final disaasa or condition	PANCREAT	TIC CANO	CER						MONTH
п	Examiner	resulting in death)	a	Due to (or as e		):				1	
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	cata be axecuted physician and s the burial-transit edical Examiner	Sequentially list conditions,	0.	Due to (or as a	consequence of	):		N COL			
90,		Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury	c								
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Box	death cer e attendin ed for use									- 1	
	at the death cert d by the attendin etached for use Physiclan/W	Part II. Other significant conditions of	ontributing to death be	t not resulting in	n the underlying	cause giv	en in Part I.	23b. Did to	bacco use conf	tribute to	the cause of death?
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	tal or Attanding P is after death.  al Director: After tied in by the funeraction of the	27. Manner of Death  1 Neturel 5 Pending investigation	28a. Data of Injui		Tima of njury M	28c. Injur	yat k? Yes 2 □ No	28d. Describe ho	w injury occurre	Ю	
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	within 2 To the comple	296 Signature and title of certifier			2	9c. Licens	e number	25	9d. Data signed	(Month,	Day, Year)
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	15	30. Name and address of person who	completed cause of d	agith (Hom 23a)	(Type Print)	D19	294	0	CTOBER	3, 2	2000
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State of Maryland / Department of Health and Mental Hygiene

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		-	The Case		200	- 1

					Certifica	ate of	Death		A	eg. No.			
		1. Decedent's Neme (First, Middle, L	est)						Date of Dea			3. Time o	i Death
	Physician	Howa	rd L. Gra	int					Wonth ntomb	er 27,	2000	4.6	)2pm
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	Examiner												
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S.	of H			10c. City, Town							10	0d. Inside C	
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1215-0020 within 72 hours after	by F	1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forces?  1 17 Yes 2 No	g sauting	1 Tyes	2 No	Specify:		Specify: White			te	
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Maryland 21215-0020	To B	Charles Lepcof	ker				F	rieda 1	da Henshew				
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	12	1				דת	9609			Septer	aber	28, 2	000
		30. Neme end address of person who				_	11 -	00 -					
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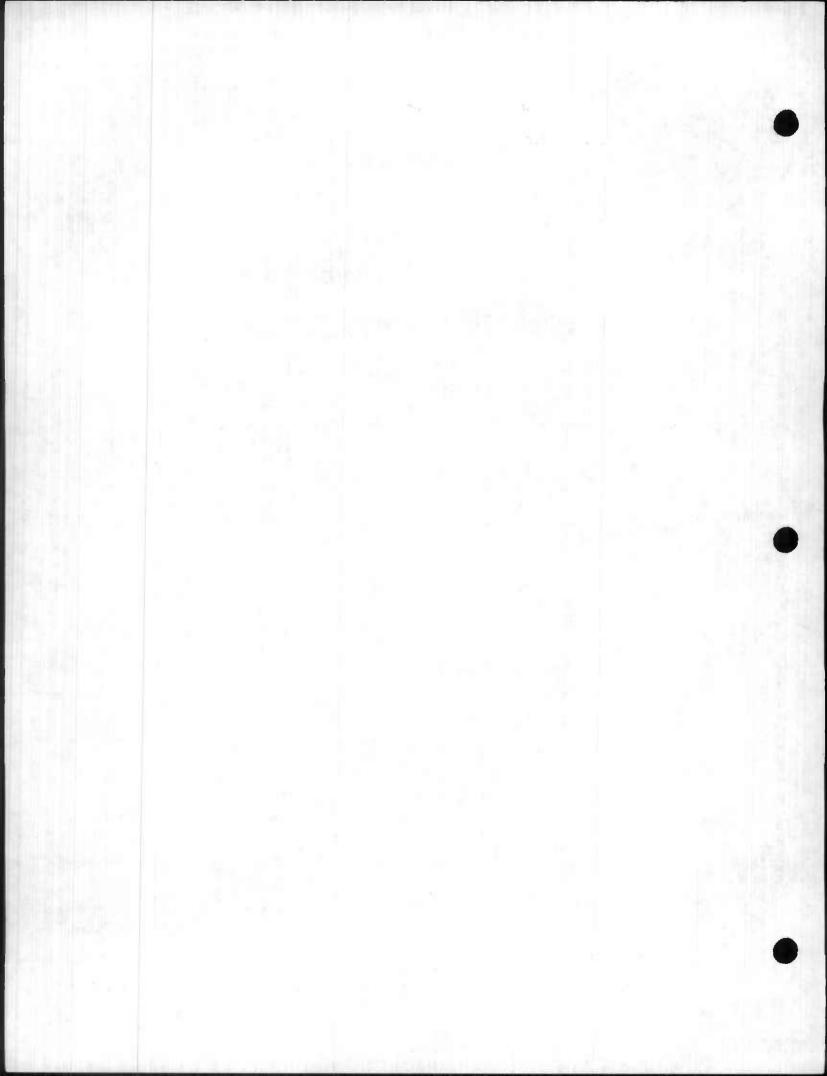
			State of I	Maryland			of Health of Death		lental Hy	giene [] Reg. No.	0 3	2796	
	Physician /Medical	Decedent's Name (First, Middle, La		Roger	Goodw	in			2. Dete of De Month Septemb	per 27, 2	Yeer	7:30 AM	
	Examiner	4a Facility Name (# not institution, given 101 Oxford		er)			4b. City, To		ocation of Death	7/	of Death comery		
	Funeral Director	5. Social Security Number 6. S 109-26-9915	Sex IM 2□F	Age (In yrs. le 83	est birthday) Yrs.	If Under 1 \ Months D	fear If Undar leys Hours	24 Hrs. Min.	8. Date of Bird (Month, De April 24	y. Yaari 4, 1917	Country)	chusetts	
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	th with	101 Oxford Str	eet				815			United			
020	gas 1 and 2 should be filed within 72 hours after death with the Manylan tof Health and Mental Hygiene.  If of Health and Mental Hygiene.  or other traumatic event, the Medical Examinar must be notified at or other traumatic event, the Medical Examinar must be notified at or other traumatic event, the Medical Examinar must be notified at or other traumatic event, the Medical Examinar must be notified at	11. Meritel Status  1 Never Merried 2 X Married  3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tas 2 If Yes, Give Year or Dete	es? ☑ No		Was Deceden f Yas, specify I□ Yes 2]X			ecify Yes or No Rican, etc.)	14. Rac Blac Specify	e - Americen i k, White, etc.		
2-0	72 ho	15. Decedent's E (Specify only highest gro			(Give	lent's Usuel C kind of work o	fone during mos	st of work	ing	16b. Kind of Business/Industry United States			
212	iene. then then omp	Elementary/Secondary (0-12)	College (1-4-5+	or 5+)		orical	Researc	cher		Departmen		ate	
Maryland 21215-0020	ould be filed within 72 ho Mental Hygiene.  arked other than "naturn artic event, the Medical I TO Be Completed	17. Fether's Name (First, Middle, Last Thoma		Goodw		18. Mothar's Name (First, Middle, Maide n Sadie Estelle Tenn							
	nd 2 should lith and Men 27 is marke r traumatic	19e. Informant's Neme/Relationship (Henry Miller/Son	Type, Print)			19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 101 Oxford Street, Chevy Chase, Maryland 20815							
Baltimore,	2 9 2 5	20a. Method of Disposition  20b. Placa of Disposition (Neme of cemetery, cremetory or other placa)  20c. Location Stephenoval from Stephenoval										on - City or Town, State	
Balti	permit. Pag Department important: I any Injury o once.	21 Signeture of Funeral Service Use	Helin	M0084	. Ro	bert A.	Pumphrey	Fune	ral Home, Bethesda,	/Bethesda- Maryland	-Chevy C	hase, Inc.	
	Physician /Medical	23a. Pert1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Finat disease or condition	plications that ceurona cause on aac		. Do not ent	er the mode o	f dying, such as	s cardiac	or raspiratory e	rrest,	Int	proximate erval Between heet and Death	
	Examiner	resulting in death)	Myelo	Due to (or	es a conseq	uence of):					1	WAR.	
× 68760,	law requires that the death certificate be assected as been signed by the attending physician and s 2 should be detached for use as the bunial-transit apieted by Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		as a conseq								
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of Vital F	yeician: The lav s certificate has director, page 2 fo Be Comp	25. Wes case referred to medical examiner?					26. Pled	e of Dea	th (Check only o		1 D Y	as 2□ No	
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	To the Hospital or All within 24 hours after of To the Funeral Direct completaly filled in by Medical Certifi												
	12+ N	29b. Signatura and title of certifier	. Have	00	my		icense number C6104			29d. Date signe Septembe			
		30. Name and address of person who Thomas C. Have 11					Avenue	, NW,	Washir	ngton, D	.c. 20	016-4901	

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year)

OCT 6 2 2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev Vaar **Physician** EDWARD GOLFER SEPT. 29 2000 6:45 PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6 Say 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** ₩ 2 F Months Deys Hours 79 Yrs. Director **GERMANY** 577-40-0087 APRIL 16 1921 Usual Residence of Decedent with the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director MONTGOMERY BETHESDA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 234 20817 Funeral 871.7 U.S.A. 14. Raca - American Indian, EWING 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0020 1 Yes 2√2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) **GROCER** SELF-EMPLOYED 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Nem 27 is marked other any Injury or other traumatic event phose. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **ABRAHAM** LEB HANNAH (UNOBTAINABLE) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. LARRY GOLFER/ 3345 SHEFFIELD CT. FALLS CHURCH, VA SON 22042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State JUDEAN MEMORIAL GARDENS 10/3/2000 OLNEY, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Senoce Licensee EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Approximete Interval Between Onsat and Death 23a. Part1. Enter the see, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart lattern. List only one cause on each line. **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical CANTO PUCMOUNTY Examiner ROSPINATORY Physician/Medical Examin Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequenca of): Nonnovita Due to (or es a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings aveilable prior to complation of cause of death? 24a. Was an autopsy performed? Completed paga 1 Yes 20No 25. Was case referred to medical Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No √Oupatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident after death 28f. Location (Straet and Number or Rural Routa Number, City or Town, State) 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C Hospital 1 Decertifying Physician: To the best of my knowledge, daath occurred at the time, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Cartifier To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier m 30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month,

9120 00 1845

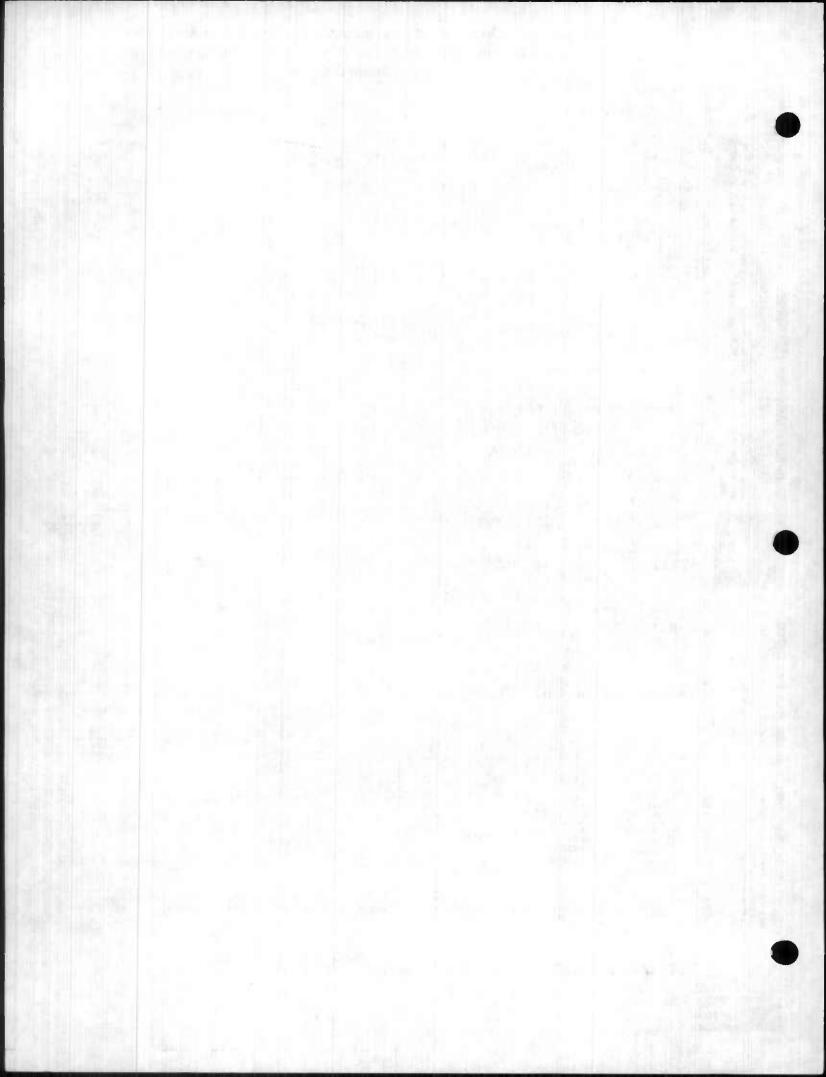
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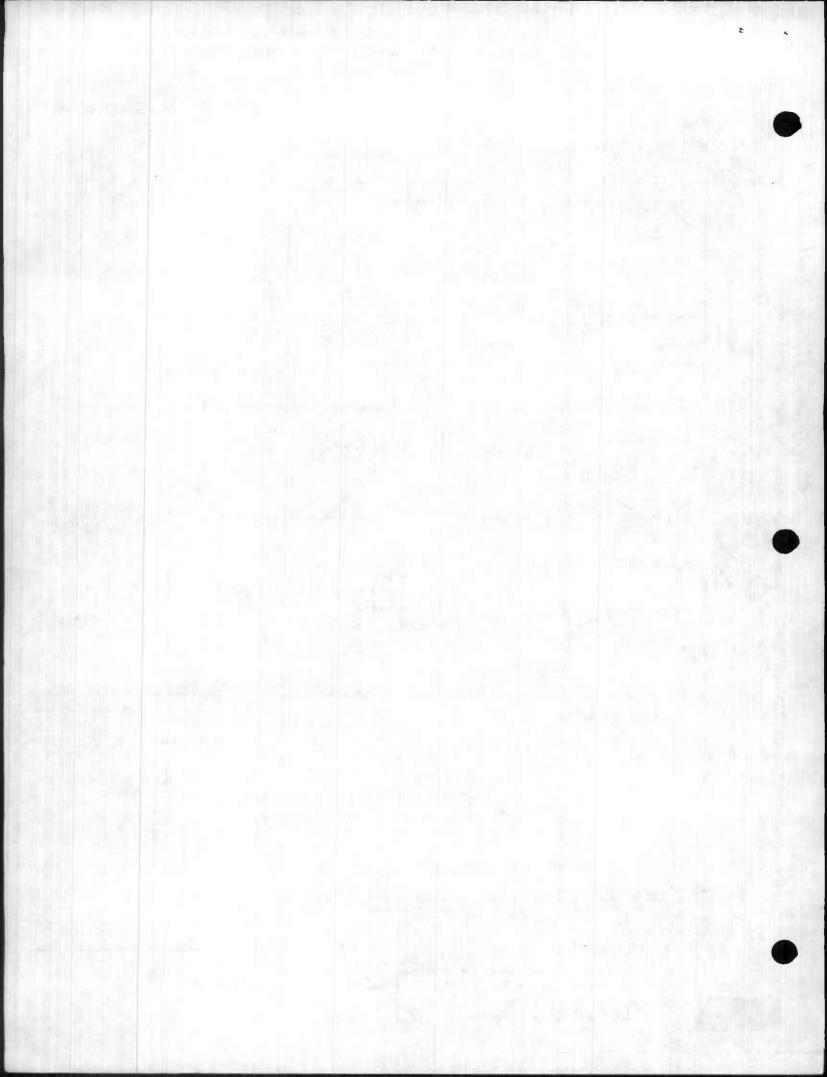
32. Registrar's Signature

SOIKE TABLE STANDS & SAR

		State of Marylan		tificate of			Reg. No.	1 321	198
Physician /Medical	1. Decedent's Name (First, Middle, Lest) Patrick F. Gilbo						ber 26,	Year 2000 3:	OOPM
Examiner Funeral Director	4a Facility Name (If not Institution, give si  Montgomery Hospice 5. Social Security Number 6. Sax 170 379-34-5440				4b. City, Town, or L  Rockville  If Under 24 Hrs.  Hours Min.		Montg	of Death  Somery  9. Birthplaca (St. Country)  Michigan	
P 1	Usual Residence of Decedent  10a. State 10b. County		y, Town or Loc	ation		TCD. 0	, 1557		da City Limits
or 28a-f sho a notified a Mrector	Maryland Montgome	ry Roc	kville						Yas 2□No
4 -	10e. Street and Number			10f. Zip Code 20850			10g. Citizen of W United S		
if, or hams 23a Examiner must by Funeral	206 Pender Place  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Evar in U Armed Forcas? 1 M Yes 2 No 195 If Yes, Giva Year or Dates: 195	04-	_	lispanic Ongin? (Span, Mexican, Puerto			e - Amarican India k, White, etc.	in,
tal Hygiens. d other than "natura event, the Medical E event the Medical E	15. Decedent's Educ (Specify only highest grade Elementery/Secondery (0-12)		(Give k	O NOT use retired	during most of work	king	16b. Kind of Bu		ross
arked other atic event, I To Be Co	17. Father's Name (First, Middle, Last) Francis Joseph Gill		, HESCO.	Liuii	18. Mother's Nam		Maiden Sumem		
7 is m	19a. Informant's Neme/Relationship (Typ				and Number or Rus				
nt. If Bern 2 ry or other	Rosalind F. Gordon  20a. Method of Disposition  1 Magurial 2 Cremation 3 DRe 4 Donation 5 Other (Specify)	emoval from State	Place of Dispos cemetery, crem-	ition (Neme of etory or other ple	ce)	Date Oct 2	20c. Location -	City or Town, Sta	
importar any injur ance	21. Semiliar il runeral Service Libense		22.	Name and Addra	Inc. 30 Maryland	ert A.	Pumphre	v Funera	1 Home/
ysician ledical aminer	Immediate Cause (Finat disease or condition resulting in death) a.	Transition Due to (c	nal Cel		oma of Bl	Ladder			ears
physician and the burial-transit clical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (c	or as a consequ	ience of):	160				
- 0	that initiated events resulting in death) Last	Due to (a	r as a consequ	ence of):				1	
etached for use a	Part II. Other significant conditions cont	ributing to death but not res	ulting in the un-	derlying cause gh	ven in Part I.	23b. Did	tobacco use cor	ntribute to the ca	use of death?
be detached to by Physic						10	Yes 2□ No	3 Probably	4 Unknown
2 should 2 should pleted							an autopsy prmed?	24b. Were auto available p completion of death?	
certificate harector, page	25. Was case referred to medical				DO Diese et Des	10	7A	1 🗆 Yes	2X No
5 G	examiner?	ospital: 1 tnpatient 2	ER/Outpatient	3 DOA ON	26. Place of Dee	ome 5 Resi		er (Specify) H	ospice
ther the	27. Menner of Deeth  1 Aneturel 5 Pending investigation  3 Suicida 6 Could not be determined	28e. Dete of Injury (Month, Dey Year)  28e. Place of Injury - At h	28b. Time of Injury		ryat rk? IYes 2 ☐ No	28f. Location (	how injury occurr	red per or Rurel Route	Number,
	29a. Certifying Physi	building, etc. (Specifician: To the best of my kno	y) wiedge, death	occurred at the ti	me, date and place	City or To	cause(s) and ma	anner es stated.	(a)
mplately fi	(Check only 2 Medical Externion	On the basis of examina and manner stated.	nion and/or inve	estigation, in my o		red at the time,		end due to the ca	
5+1	1			D0054				ber_26,_	
	30. Name and address of person who cor Cheryl Aylesworth				ne, N.W.,	Washing	eton. D.	C. 2080	7
State	31. Date filed (Month, Dey, Year)	32. Registrar's Signa		/	,,		, ,		

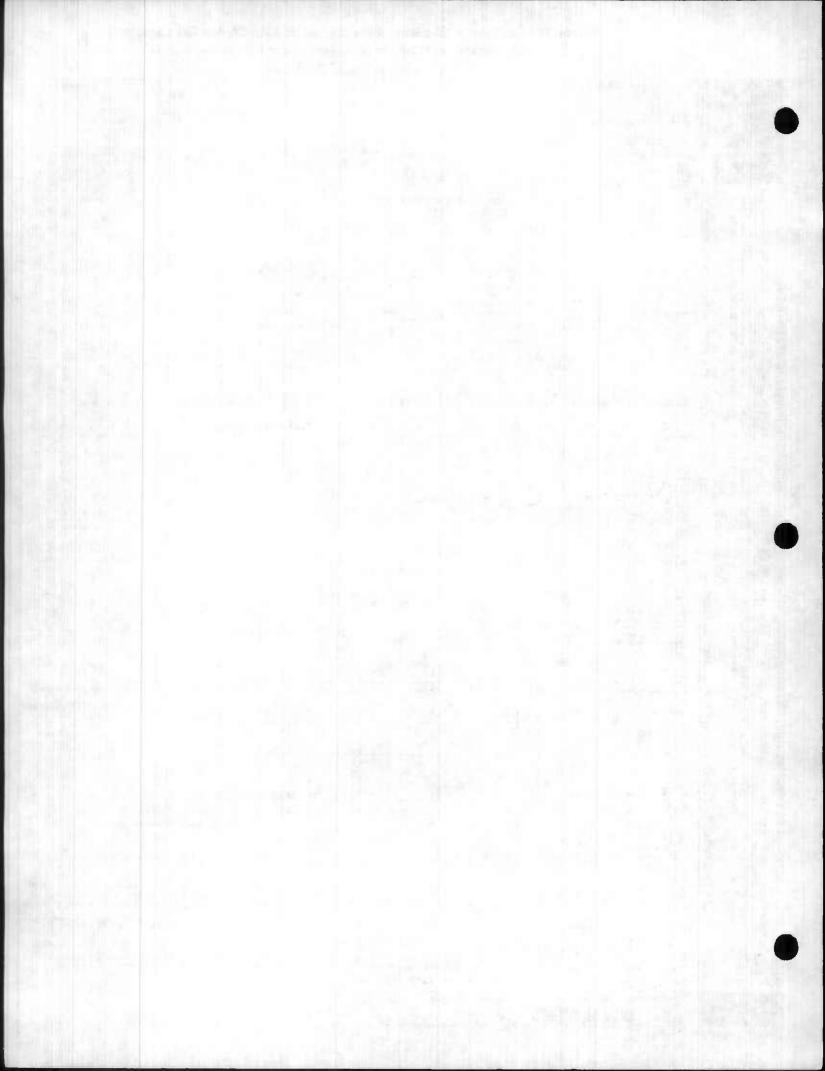


7m	and #20a	3 1	0 /4 /2000 PMG Mond	State of M	larylan		artment rtificate			and M	lental Hy	-	0 3	32799	
AIII	ena #290		1. Decedent's Nama (First, Middle, La			00	imouto	, 01 2	Joann		2. Data of De			3. Time of Death	-
l <sub>e</sub>	Physicia /Medica	_	Kareemeh N. Gharf	eh						6	Octobe	1 Day	2000	2:08 Pm	)
	Examine	41	4a Facility Name (If not institution, gir		r)	11 75		4	b. City, Tov	wn, or Lo	cation of Deat	h 4c. Count	y of Death		
		_	Doctors Community						anhan				e Geo		
	Funeral			Sex 7. A 1 □ M 2 💢 F		last birthdey) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Data of Big (Month, De	th ey, Year)		laca (Steta or Foreign try)	
	Director	-	Usual Residence of Decedent		70						Nov 23	, 1929	Pale	stine	-
	how		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10	0d. Inside City Limits	
	Sa-f		Maryland Prince G	eorge's	Bow	ie								1) Yas 2□No	
	vith th		10e. Street and Number				10f. Zip (	Code				10g. Citizen of	What Coun	try?	
	eath 23	eral	12006 Terra Lane	12. Was Deceden	t Ever in U	S 13	207		ispanic Orlo	nin? (Spe	cify Yes or No	USA 14. Ba	ce - America	an Indian.	
20	within 72 hours after death with the Manyland she. than 'natural', or items 23s or 28s-f show he Medical Examinar must be notined at	by Funeral	1 Nevar Married 2/1 Married 3 Widowed 4 Divorced	Armed Forces  1  Yes 2 X  If Yes, Give  Year or Dates	? ] No		If Yes, specif		n, Mexican Specify:	, Puarto	ecify Yes or No Rican, etc.)		ock, Whita, a	atc.	
Maryland 21215-0020	natural, or		15. Decedent's E	ducation		16a. Dece	dent's Usual	Occupa	ation			16b. Kind of B	Susiness/Ind	Justry	
215	hin 7.	Completed	(Specify only highest grant Elementary/Secondary (0-12)	ada completed)  College (1-4o)	5+)	(Give	dent's Usual kind of work DO NOT use	done de retired	during most )	t of work	ng				
21	72 To 10 To	000	6			Homen	aker					Own Ho			
pue	Head double	n n	17. Father's Name (First, Middle, Last	)					18. Mothe	r's Name	(First, Middle	, Meiden Sume	ma)		
ryla	d 2 should th end Men 7 is marks traumatic	2	Jiryis Tawasha  19e. Informent's Neme/Reletionship	Time Brint		10h Mali	no Address				G. Dugn	an Der, City or Town	State 7in	Code)	_
Ma	d 2 si th en th en traur		Nicola Gharfeh/	Husband			6 Teri					20715	i, 31616, 21p	C000)	
re,	Heelth tem 27	- 1-	20a. Method of Disposition	1-6-2	20b. F	Place of Disposemetery, cre				DOW.	Date	20c. Location	- City or To	wn, State	-
E O	Page ent of mt: H I ry or		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		8					v 10	0/5/00	Silver	Spri	ng. MD	
Baltimore,	Department of Heelth of Important: if hem 27 is any injury or other tra	-	21. Signature of Funaral Service Lice	nsee								1 Home,			-
8	88188		J. Keis Stile											g, MD 2090	1
	Physician		23a. Pakt. Enter tha disease, or com shock, or heart feilure. List only	plications that cause one ceuse on each	ed the daat line.									Approximate Interval Between Onset and Death	
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	Sep									days	
L		ĕ			Due to (c	or as a conse	quence of):	0.6	mal.	disa	are		1	Years	
	ocuted nd transi	Examiner	Sequentially list conditions,	b	Due to (c	or as a conse	quance of):	10							-
90,	te be executed ysician and le bunal-transit		Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury	0	2	or as a conservabele.	ie m	relli	rus					years	
(68760	eath certificate be executed attending physician and for use as the bunal-transit	9	thet initieted events resulting in death) Last			r as a consec									
Вох	ath ce ittendi	Physician/Med		d											
P.O.	res that the de signed by the a I be detached I	ysic	Part II. Other eignificant conditions	contributing to death	but not res	ulting in the u	inderlying ca	use giv	en in Part I.					the cause of death?	
	that the ded by deta	Dy Pr	Agrentinia	^							1	Yee 2 No	300 Prot	bably 4 Unknown	1
Division of Vital Records,	The law requires that the death certifical the has been signed by the attending phypege 2 should be detached for use as the	Completed b	L FUOT	Mu								s an autopsy ormed?	ava	ere autopsy findings allable prior to mpletion of cause death?	
Re	he law e has age 2	Eo									10	Yas 2 No		☐Yes 2☐ No	
ital			25. Was case referred to medical						26. Place	of Deat	h (Check only				_
1 <		0	examiner?	Hospital: 1 Nnpa	tiant 2	ER/Outpatie	nt 3 DO/	A Oth	er: 4 🗆 Nu	ırsing Ho	me 5 Res	idenca 8 🗆 Ot	her (Specify	y)	
0 1			27. Menner of Death 1/█ Natural 5 ☐ Pending	28a. Date of In (Month, D	jury ley Year)	28b. Tima o Injury		Bc. Injun Wor			28d. Describe	how injury occu	irred		
Sio	eath the or:	Cat	2 Accident investigation		aliana Atta		M		Yes 2 🗆		28f Location	(Street and Num	her or Pure	al Route Number,	
DIV	or Attandi	Certification:	4 Homicide determined	28e. Placa of I building,	etc. (Specif	y)	reet, tectory,	OTHOS			City or To	wn, Stete)	iber or mora	THOUSE PURILIDES,	
A				nysician: To the besing and manner:	of examina										
	outhin comple		29b. Signature and title of certifier	and marrier	natog.		29c.	Licens	e number			29d. Date sign	ed (Month,	Dey, Year)	-
	3			mp	death the	- 00c) (T	Pain!	0	53	3411		Octobe	3	3000	
			30. Name and address of person who 3060 mitchelly	He Rd	# 10.	3	3 owle	,	MD		2071	gr.Jagdi	sh Sh	esadria	
	State Registra	r	31. Date filed (Month, Day, Year) UCT 0 4 2		trar's Signa	B.	Spa	ch	,						



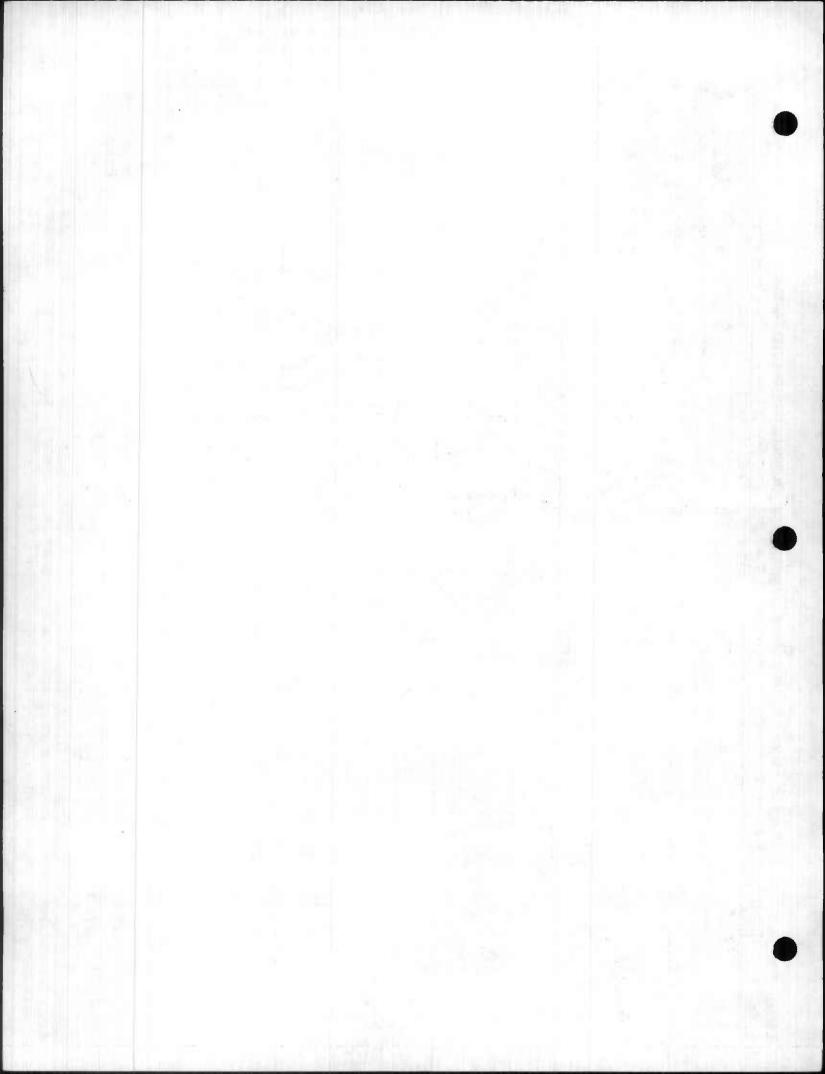
State of Maryland / Department of Health and Mental Hygiene

			Certificate of	Death	Rec	a. No.	
	1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
Physician /Medical	Charles	Edward Gen	nies		Month Septembe	r 29, 2000	11:40 PM
Examiner	4a Facility Name (If not institution, give st SHADY GROVE A		SPITAL	4b. City, Town, or Lo	cation of Death	4c. County of Death MONTGOI	1
Funeral Director	5. Social Security Number 8. Sex 215–58–9263	7. Age (In yrs. last I	birthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, ) May 18,	rear) Co	nplace (State or Foreign untry) cyland
ž.	10a. State 10b. County	10c. City, To	own or Location				10d. fnsida Clty Limits
r must be notified at near in Director	Maryland Montgomer	y Mor	ntgomery Vil	lage			1 Yes 2 No
23a or 3 unt be n	10e. Street and Number 9483 Chadburn Place		10f. Zip Code 2088	6		g. Citizen of What Co Inited Stat	
Framina by Fu	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Year or Dates:	13. Was Decedent of ff Yes, specify Cub  1 ☐ Yes 2 ☒ No	oan, Mexican, Puarto	city Yas or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
dical	15. Decedent's Educa	ation 16	Sa. Decedent's Usual Occu (Giva kind of work done	pation during most of worki	na 10	6b. Kind of Business/I	ndustry
ygiene. ner than "nu r, the Medi Complet	Elementary/Secondary (0-12)	College (1-4or 5+)	(Giva kind of work done life. DO NOT use retire Contractor			Warehous	۵
- B B B	17. Father's Name (First, Middle, Last)		Concractor	18. Mothar's Name	(First, Middle, Mi		-
marked metic er	Ernest I	lackey			Lillian	Genies	
and and	19a. fnformant's Name/Relationship (Typ	e, Print) 1:	9b. Mailing Address (Stree	t and Number or Rurs	I Route Number,	City or Town, State, 2	ip Code)
partment of Health portant: if Item 27 y Injury or other II CB	Nancy A. Genies/Wif  20a. Method of Disposition  1 52 Burial 2 Cremation 3 Ra 4 Donation 5 Other (Specify)	moval from Stata 20b. Place ceme	483 Chadburn of Disposition (Name of tery, crematory or other pie of Heaven Ce	emetery 1	Date 20	Oc. Location - City or	Fown, State
Departmen Important any Injury BBCs.	21 Signature of Funeral Service Licenses	1000	22. Nama and Addr	De	Vol Funer		m 20877
ysician Medical	23a. Part1. Enter the diseasa, or complic shock, or heart failure. List only one	ations that caused the death. Do cause on each line.	o not enter the mode of dy	ing, such as cardiac c	r respiratory arras	st,	Approximate Interval Between Onset and Death
caminer	disease or condition resulting in death) a.		a consequence of):				200000
je je		Due to (or as	a consequence ory.				
s physician and its the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury	Dua to (or as	a consequence of):				
5 5	that initiated events resulting in death) Last	Dua to (or as a	a consequence of):				
e attendir od for use sician/A	Pert II. Other significant conditions contr	ibuting to death but not resulting	in the underlying cause g	iven in Part I.	23b. Did tob	acco usa contributa	to the cause of death?
ed by the attendidacted detached for use		CELL LUN			1 💢 Yes	8 2□No 3□Pr	obably 4 Unknow
cata has been signed by the page 2 should be detached Completed by Physic					24a. Was an parlorm	ed?	Were autopsy findings available prior to completion of cause of deeth?
page page					1 ☐ Yes	2 NO No	Yes 2 No
# o	25. Was case referred to medical examinar?			26. Place of Deet	(Check only one	)	
5 D	1 Yes 2 No		outpatient SEI DOA			nce 6 Other (Spec	eify)
r: After the funeration:	27. Manner of Death  1 Netural 5 Pending  2 Accident invastigation	28a. Dete of Injury (Month, Day Year)	Injury M 28c. Inju	ry at ork? Yes 2 No	28d. Describe hov	v injury occurred	
within 24 hours after death. To the Funeral Director: After the completaly filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
he Funeral pletaly fille edical C	29a. Certifier 1 Certifying Physic (Check only one)	clan: To the best of my knowled er: On the basis of examination a and manner stated.	ge, death occurred at tha t and/or investigation, in my	ime, date and place, a opinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner es le end place, and due	stated. to the cause(s)
Mec Mec	29b. Signature and title of certifier	and manifel stated.	29c. Licen	se number	29	d. Date signed (Monti	h, Day, Year)
	> Chilippul	L MD					30,2000
	30. Name and address of person who com		(Type, Print) DR.	CHITRA K	AJAGOP	AC, M.D	
State	31. Date filed (Month, Day, Year)	32. Registrer's Signature			2023		
Registrar	OCT 0 4 200	1) Denevas	B. Spork	2			



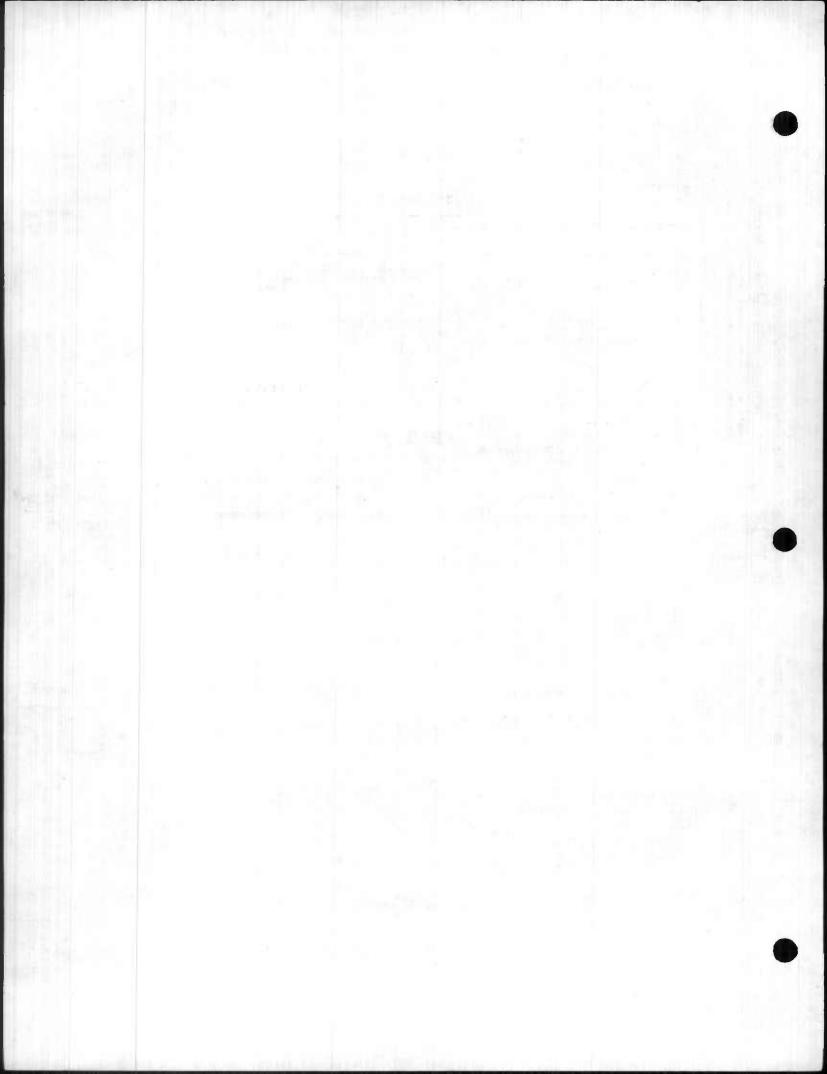
State of Maryland / Department of Health and Mental Hygiene 00 2200 i

			Ce	rtificate	of Death		Reg. No.	32801
	1. Decedent's Name (First, Middle, Last	)				2. Date of De Month	ath	3. Time of Death
Physician /Medical	Georgia Lee Ga	nas				Octobe		
Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, o	r Location of Death		f Death
	Casey House				Rockvill		Montg	omery
Funeral Director	377-40-7300	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Months	Year If Under 24 Hours Mi	8. Date of Birl (Month, Da September	y. Year) er 5,1934 I	9. Birthplace (State or Foreign Country) Kentucky
5 k.	Usual Residence of Decedent  10s. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
with the Maryle t or 28s-f sho be notified at Director	Maryland Montgome	ry Ger	rmantow	-				11⁄2 Yes 2 □ No
	19042 Cherry Bend	Drive		10f. Zip (	20874		United	States
020 020 020 020		12. Was Decedent Ever in 1 Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	U,S. 13.		nt of Hispanic Origin? (y Cuban, Mexican, Pue	(Specify Yes or No orto Rican, etc.)		- American Indien, c, White, etc. White
7277 7277 7277 7277 Feel	15. Decedent's Edu (Specify only highest grad	cation le completed)	16a. Dece	dent's Usual	Occupation done during most of w	orkina	16b. Kind of Bus	iness/Industry
ind 21215-0 be filed within 72 ho all Hygiene. d other than *natur event, the Medical.  Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use	done during most of w retired)	on any	Newspa	ner
Hied w	12	2		Editor			-	
	17. Father's Name (First, Middle, Last)	บาไไ				ame (First, Middle,		,
ahould name of Mary Is	George Washington  19a. Informant's Name/Relationship (7)		10h M-20	an Addman (	Street and Number or i	ia Nort		Note Tie Codel
Z paca	Cassandra Barbour	/ Daughter	5703	Seasi	de Walk, I	ong Beac	h, CA 90	803
Sattimore, semit. Pages 1 at Department of Healtmoortant: if Nem Into Into Into Into Into Into Into Into	20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	Removel from State Geo	Place of Dispo cometery, cre Wash	matory or oth Univ Center	versity	October 1	Washing	ton, D.C.
Castim permit. Pag Department Important: I any Injury o	21 September of Funeral Service Lights	Cerola	- Z P	2. Name and olumbi	Address of Facility La Mortuary Ox 58007 Wa	Service shington	Inc. 2	0037
Physician	23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the dea ne cause on each line.	ath. Do not en	ter the mode	of dying, such es cardi	ac or respiratory e	rest,	Approximete Intervel Between Onset and Death
Examiner	Immediate Cause (Finat disease or condition	Metastatic	Carcin	noma				11 Months
	resulting in death)		(or as a conse					8
al se de		Squamous C	ell- U	nknown	Primary			
barroused fleate be executed physician and is the buristransit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to	or es a conse	quence of):				
2 2 5	that initieted events resulting in death) Last		or as a consec	quence of):				
P.C. BOX								1
y sign of the de	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	inderlying car	use given in Part I.	23b. Did	lobacco use cont	tribute to the cause of death?
						- 10	Yes 2 No	3 Probably 4 ☐ Unknown
Peen should							an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
r · - a E						10	res 2 No	1 ☐ Yes 2 ☐ No
VITAL The rector, par	25. Was case referred to medical examiner?					eath (Check only o	ne)	
_ E 00 0	1 Yes 2 No		] ER/Outpatie		Other: 4 Nursing	Home 5 ☐ Resid	dence 6 10 Othe	(Specify) Hospice
Attending Phy or death.  ector: After thi by the funeral iffication: T	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	M 28	c. Injury at Work? 1 Yes 2 No		now injury occurre	
DIVISION OF Attending P is after death.  al Director: After led in by the funer.  Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Special Control of the	nome, ferm, str	reet, fectory,	office	28f. Location (: City or Tox	Street and Numbe vn, State)	er or Rural Route Number,
To the Hospital or a within 24 hours after . To the Funeral Direct Completely filled in Medical Certif		nician: To the best of my kn ner: On the basis of examin and manner stated.						
withir Found	29b. Signature and title of certifier	2			License number			(Month, Day, Year)
.18	\$ (r.	Libre	M	D D	09470		October	3, 2000
	30. Name and address of person who co	ompleted cause of death (Ite	nn 23a) (Type,	Print)				
	Eugene P. Libre, 1	M.D. 10	400 Co	nnecti	cut Avenue	, Kensing	rton, MD	20895
State Registrar	31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature 4	lan	V.			



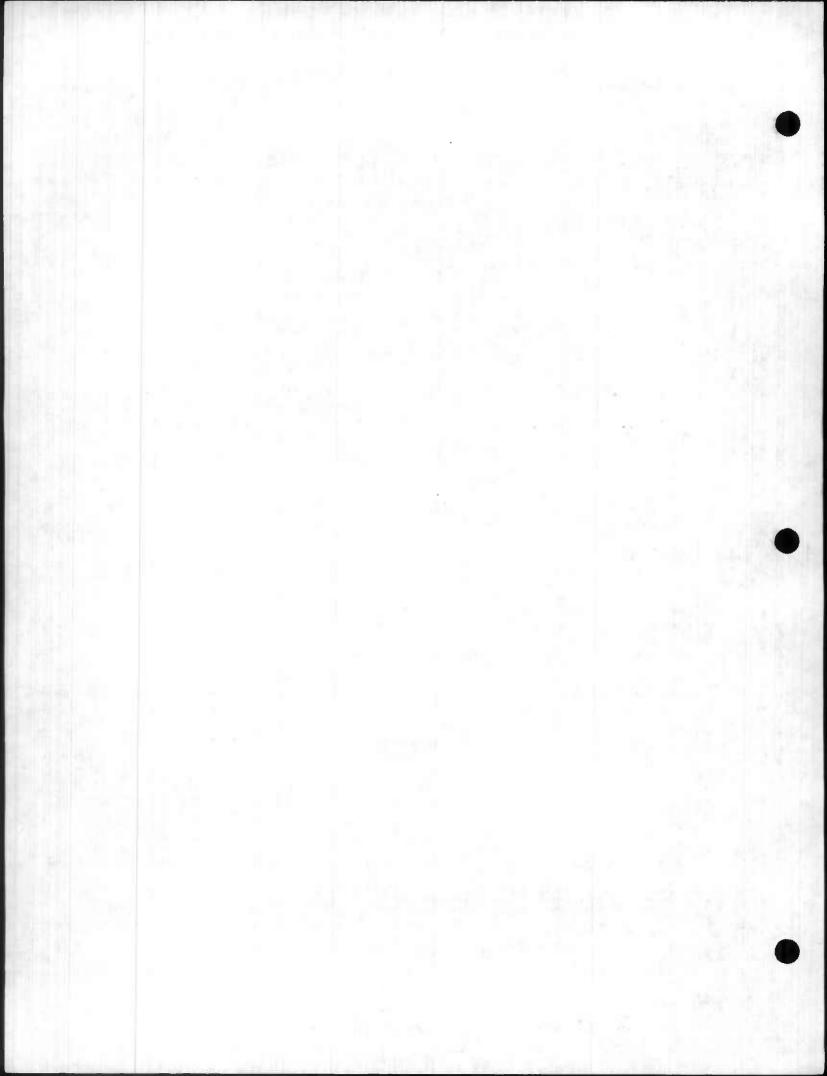
State of Maryland / Department of Health and Mental Hygiene amend item 10a, b, c, e, f 11 per informant 6789 11/29/00 yf 2802 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Ethe1 Gamer Sept. 28, 2000 8:50P. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Yeer If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) July22, 1908 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 10 M 20 F Months New York 578-50-0673 92 Yrs. Director Usual Residence of Decedent the Maryland 10b. County 10a. Stete Maryland 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Montogomery County Rockville Washington, D.C. Director 1 X Yes 2 No 10e. Street and Number 6121 Montrose Road 10f. Zip Code 10c. Citizen of What Country? 3512 Rittenhouse St., N.W. <del>20015</del> 20502 United States Funeral filed within 72 hours after death 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Merital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Merried - Never Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: by 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pagas 1 and 2 should be filed w.
Department of Health and Mental Hygien.
Important: if frem 27 is marked other tha
any injury or other traumatic excess. Housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Jacob Huchberger Gertrude Oppeheim 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Perlman (daughter) same as #10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington Hebrew Cemetery 10/2/2000 Washington, D.C. 21. Signature of Funeral Service License 22. Nama and Address of Facility
Donald V. Borgwardt Funeral Home, P.A. mente 4400 Powder Mill RD. Beltsville, Maryland 20705 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** ral /Medical Immediate Cause (Final disaasa or condition resulting in death) **Examiner** Due to (or as a consequence of) Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) P.O. Box 68760 Physician/Medical Due to (or as e consequence of) USB ò ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detact 1 Yes 2 No 3 Probably 4 Unknown 2 Division of Vital Records. 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 212 No 2 N oepital or Attanding Physician: I hours after death. uneral Director: After this certifica shy filled in by the funeral director, 25. Was case rafarred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: A Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 2 Accident 5 Pending 1 TYes 2 No investigation 6 Could not be To the Hospital or Attai within 24 hours after dea To the Funeral Director completely filled in by th 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and titla 29c. License number 29d. Date signed (Month, Day, Year) 29 2000 12 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) Locker 6121 Mon 32. Registrar's Signature State 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene 32803

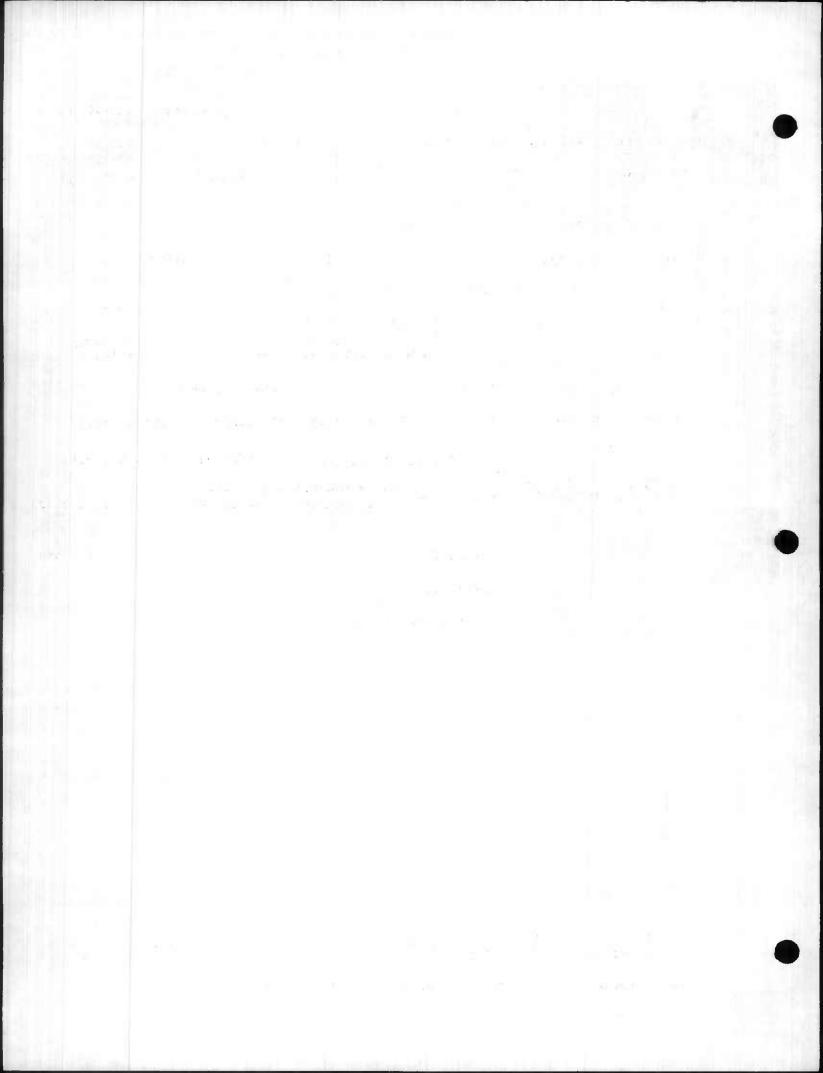
			Cert	ificate of l	Death	Reg.	No.	32803		
	1. Decedent's Neme (First, Middle, I	ast)	ITVIS:			2. Date of Death Month	Dev Y	3. Time of Deeth		
Physician /Medical	IVIPTI 7 (1)	CUMMINS				Oct 1	2 2	000 2:20A1		
Examiner	An English Name // not Institution	rive street end number)		4	b. City, Town, or Loc	cation of Deeth	4c. County of	Death		
3E 7	HUWARD COUL	ITY GENER	CALH	SPIAL		MB1A		WARD		
Funeral Director	213 26 4702	Sex 7. Age (In yrs 72.	. rust birtirually/	If Under 1 Yeer Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye May 25,	1928	Birthplaca (State or Foreign Country) Maryland		
2 .	Usual Residence of Decedent  10a, State 10b, County	10c C	aty, Town or Loca	ation				10d. Inside City Limits		
the party of all all all all all all all all all al		_						1 ☐ Yes 2 🖫 No		
with the Marylan a or 28a-f show be notified at	MD Howar	u	Elkride	10f. Zip Code		100	Citizen of Wh	at Country?		
23a or unt be	6734 Montgomery	Road		210			United	States		
21215-0020 signer. The Medical Examiner in Medical Examiner.	11. Maritel Stetus  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in ( Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		es Decedent of H Yes, specify Cubs ☐ Yes 210 No	lispanIc Origin? (Spe an, Mexican, Puerto I Specify:	city Yes or No- Rican, etc.)		American Indian, White, etc. White		
5-0 72 ho		Education	16e. Decede	nt's Usual Occup	ation duning most of working	160	. Kind of Busi	ness/Industry		
21215 ad within 7 ygiene. wer than 'n t, the Madi	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of workir					
Manual S	12		Pa	ayroll C				verment		
D STORE OF		st)			18. Mother's Name	(First, Middle, Mai	den Surname)			
yla Mente Me	Charles H. Detze	1				MacDona				
2 sty	19a. Informant's Name/Relationship				and Number or Rura					
and	Ronald J. Cummin	•			ry Road El					
Pages 1 hant of Hs ant: If Hsn ury or oth	20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spe	Removal from State		ition (Name of atory or other place ematory				ty or Town, State		
Balt Depart Import any inj	21. Signature of Funeral Service Lic	onsee MOLDYA	D. 22 Ha	Name and Address Try H. V	ss.of Facility Witzke's E	Camily Fu	neral F	Hame, Inc. Lty, MD 21043		
	23a. Pert 1. Enter the disease, or co	mplications that caused the de						Approximate		
Physician	shock, or heart failure. List on	ly one cause on each line.						Intervel Between Onset and Death		
/Medical	Immediate Cause (Final	Room	1-	10,0	. ~			· da.		
Examiner	resulting in death)	a. Dunto	lor ac a consort	gan tu	4E			adys		
و المستعملات	Due to (or as a consequence of):									
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oxec exec an an hist-tr	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(0. 00 0 00.004					U		
68760, filicate be experience of physician as the burial padical F	Cause (Disease or injury that initiated events	C. Due to	or as a conseque	ence of):						
		d								
S, P.O. Box ss that the death cent igned by the attendin be detached for use by Physician/M						Towns and the				
o. o. y the de check	Part II. Other significant conditions	contributing to death but not re	sulting in the und	derlying ceuse giv	en in Pert I.	. 1		ibute to the cause of death?		
P detad	Metastatic	lung C	arcin	omo		Yes	2□ No 3	Probably 4 Unknown		
ord requir	Chronic St	structive	puli	naan		24a. Was an a performe		24b. Were autopsy findings aveilable prior to completion of cause		
Vital Rec stelan: The law certificate has b director, page 2 s		h = 0 8-1	1 -00	7 +,	0	1 ☐ Yes	20 No	of death?		
f Vital Re lystelan: The last standing to the complete of the		mac p	ont	anon	26. Place of Death					
Of Vita Physician: this certifical director.		Hospital: Inpatient 2	TER/Outpatient	3 DOA Oth	or:	ne 5 Residenc	e 8 DOther	(Specify)		
Phys rethis		28a. Date of Injury	28b. Time of	28c. tnjur Wor		28d. Describe how				
ding ding	Natural 5 Pending investigat	(Month, Day Year)	Injury		Yes 2 □ No					
Division of the or Attending P as a factor. After ted in by the timest Certification:	3 Suicide 6 Could not determine	be 28e. Place of Injury - At building, etc. (Spec		et, factory, office		28f. Location (Stree City or Town, S	at and Number State)	or Rural Route Number,		
A STATE OF	3									
To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this complataly filled in by the funeral di Medical Certification: To	29a. Certifier Certifying (Check only one)	Physician: To the best of my kr aminer: On the basis of examin and manner stated.	nowledge, death on nation and/or inve	occurred at the tirestigation, in my o	me, date and place, a ppinion, death occurre	and due to the caused at the time, date	e(s) and mani and place, an	ner as stated. d due to the cause(s)		
Within to the complete complet	200. 0.9.17.0.47.10 1.10 0. 00.11.10.	. 0 = .		29c. Licens				(Month, Day, Year)		
	1 /1/15 h	10, FCCP		D 30	6845	C	ct 12	2,2000		
	30. Name and address of person with	o completed cause of death (Ite	ern 23a) (Type, P	4 4	- CHI NG	MYEN,	MD,			
	7350 grace	- brive, C	olum	b12,	MO	21044				
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature							
Registrar	OCT 13	2000 Beneva	B.	book	1					



State of Maryland / Department of Health and Mental Hygiene

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					Cer	tificate	of L	Death		Reg. No.	0	02004	
Physic	an	1. Decedent's Nama (First, Middla, La				2. Data of D		Year	3. Tima of Death				
Physician /Medical Examiner		Grace Belle Greeley							September 25,2000 1:50				
		4a. Facility Nema (If not Institution, gir					4	b. City, Town,	or Location of Dea		y of Death		
		Caroline Nursi	ng Home,	Inc.				Dent	on	Ca	roli	ne	
Funeral		The state of the s	Sex 7. Ag	ga (In yrs. last		If Undar 1 Months	Yaar Days	If Undar 24 H Hours M		irth	9. Birth	placa (State or Foreign	n
Director		004-10-0234 Usual Residence of Dacedant	ILIM ZAIF	9	3 <sup>Yrs.</sup>				August		Mair		
how		10e. Stata 10b. County		10c. City, To	own or Loc	cation						10d. Insida City Llmits	à
T S	cto	Maryland Carol	ine	Ma	rydel	L						1 ☐ Yas 2 🗷 No	A Mining
or 2	Director	10e. Street and Number				10f. Zip C	oda			10g. Citizen of	What Cour	ntry?	_
23										United	State	es	
I health and Mentel Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Evantinet must be notified at	Funeral	11. Maritel Status	12. Wes Decedant	12. Wes Decedant Evar in U,S. 13. Was Armed Forcas?		Vas Decedant of Hispanic Origin? (Specify Yas, specify Cuben, Maxicen, Puarto Ricer			(Specify Yas or Narto Ricen, etc.)	lo- 14. Ra	ce - Americ	cen Indian,	
	by	1 ☐ Navar Married 2 ☐ Marriad 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yas 23€ If Yas, Giva Yaar or Datas:	No	1 □ Yas 2 € 1			Specify:	,	Specia			
	ted	15. Decedant's E	ducation	16	a. Deced	ent's Usual	Occupa	atlon		16b. Kind of B			
then "r	Completed	(Spacify only highest gr Elamentery/Secondary (0-12)		a complated) (G lift Collega (1-4or 5+)			ratined	turing most of v Cal	vorking		ology		
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Vent	Be (	17. Fathar's Nama (First, Middla, Last	)					18. Mothar's N	lama (First, Middl	a, Maiden Sumei	ne)		
orke otic e	LO L	Harry Ashto	n Spauldi	ing				Jessi	e Elizal	oeth Bak	er		
Is marked o		19e. Informant's Name/Ralationship	Type, Print)	1:	9b. Mailing	g Addrass (	Street a	and Number or	Rural Routa Num	ber, City or Town	, Steta, Zir	o Code)	
em 27 i		Andrea S. Norris	Niece	9	3017	River	vie	w Road,	Lawrence	ce, Kans	as 6	6049	
oth oth	10	20a. Mathod of Disposition		oome.	of Dispos	ition (Nama atory or oth	of ar plac	e)	Data	20c. Location	- City or To	own, Stata	
Important: if Item 2 any injury or other once.		1 ☐ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spaci				remat			9/26/00	Dover	. Del	aware	
- In-		21. Signature of Funaral Sarvice Lice		capi				s of Facility	7, 20, 00	20161	, DCI	aware	
any lr		& Dandoshi	V. Mr	ve					ne, P.A.				
ying physician end see es the bural-transit	ai Examiner	rasulting In deeth)  Sequentially list conditions, if any, leading to immadiata cause. Enter Undarlying Cause (Disassa or Injury	b. Asp	Due to (or es Diration Dua to (or as Cheimer	n e consequ	Jance of):						1 month	
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s been s	Completed b		24a.								ev	fere eutopsy findings vallabla prior to ompletion of ceusa death?	
pa	Con								1□	Yas 2⊠No	1[	☐ Yes 2☐ No	
director,	Be	25. Was cesa rafarred to medicel axaminer?						26. Plece of D	eath (Check only	one)			-
ō	70	1 ☐ Yas 2 ☒ No	Hospital: 1 Inpatio	ant 2 ER/0	Dutpetient	3□ DOA	Othe	ar: 400 Nursing	Homa 5□Res	☐ Residence 6 ☐ Other (Specify)			
: After this e funeral di		27. Menner of Daath 1 ⊠Natural 5 □ Panding 2 □ Accident Investigatio	ary Year) 28b	28b. Tima of Injury at Work?  M 28c. Injury at Work?  1 Yas 2 No				1	28d. Describe how Injury occurred				
ed in by the	Certification:	3 ☐ Sulcida 6 ☐ Could not b datarmined	jury - At homa, c. (Specify)	At homa, farm, straet, fectory, office 28f.					28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)				
completely filled in	edical (	29a. Cartifiar (Check only one)  1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steled.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
To the Funeral Direct completaly filled in by	Me												
- 0		1 Conun	No	SHE	A		D <b>5</b> 1	539		9-25-0			-
		30. Name end addrass of person who		1 0									
Sta	te	Karen Moffett, M. 31. Data filed (Month, Day, Yaar)		n Lane, rar's Signatura	Den	ton,	Mar	yland 2	1629				



State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: 26 PER PHY G787 10-16 Certificate of Death

Beg. No.

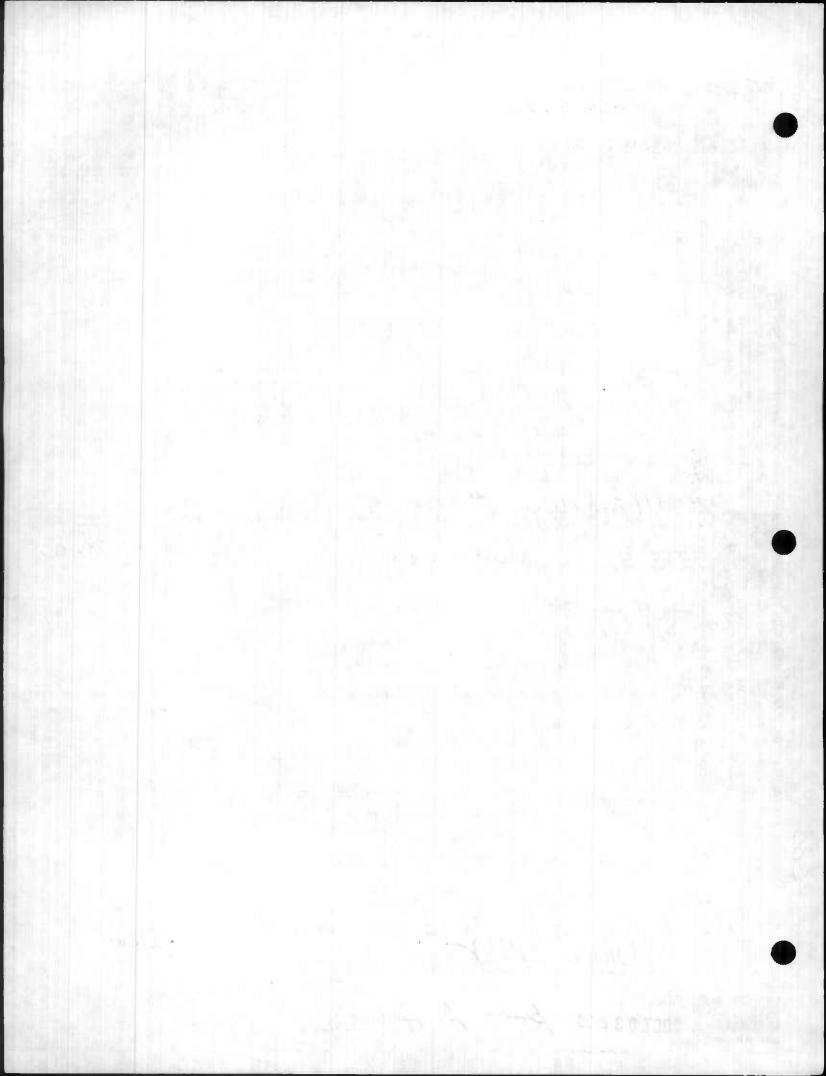
1 3 2 8 0 5

0	AMEN	1. Decedent's Name (First, Middle, La	PHY G/8/ 10-1	6 Certificate of	Death	2. Dete of De		3. Time of Death				
/M	Physician /Medical	ROBERTA ELIZ	ABETH GATES		Month SEPTEME	Day BER 19 2	Year 000 8:38 PM					
	Examiner	4a Facility Neme (If not Institution, giv	4a Facility Neme (If not Institution, give street and number)					of Death				
		13909 BLACK VALLE	Y ROAD		FLINTST		ALĪ	EGANY				
	Funeral Director	220 20 7270	ex ☐ M 2√x F 69	birthday) If Under 1 Yea Months Dey			9. Birthplace (State or Foreign Country)  W.VA.					
	p a	Usual Residence of Decedent  10a. State 10b. County	10c City T	own or Location				10d. Inside City Limits				
	vith the Maryler or 28s-f show be notified at Director	MARYLAND ALLEGA		CUMBERLAND	1			1 ☑ Yes 2 ☐ No				
	\$ 0 B 0	10e. Street and Number 308 MAGRUDER STRE		10f. Zip Code 215			10g. Citizen of What Country? U.S.A.					
21215-0020	or after all, or the mine	11. Maritel Status  1 Never Married 2 Married  3 🖾 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:	13. Wes Decedent of II Yes, specify Cu	Specify Yes or No to Rican, etc.)	Blad	ace - Americen Indian, lack, White, etc.					
5-0	2 분류 승	15. Decedent's Ed (Specify only highest gra		6a. Decedent's Usual Occ (Give kind of work don	e during most of wo	rkina	16b. Kind of Bu	f Business/Industry				
12	within than than than	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retir	ed)		*****					
	other the vent, the	12		HOME MAKE				MAKER				
and	D SOLD	17. Father's Neme (First, Middle, Last)				me <i>(First, Middl</i> e, CATHERIN		*				
2	marked marked marked	HARRY EMMITT SANF										
, Maryland	is 1 and 2 should be filed.  If Health and Mental Hyg.  If the The marked other other traumatic event,  To Be C	19e. Informant's Name/Reletionship ( STEPHANIE R. GATE	S DAUGHTER			AD FLINT	STONE M	ARYLAND 21530				
~	00 -	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donetion 5 ☐ Other (Specify	Removel Irom Stete	of Disposition (Name of otery, crematory or other plants of CEMETERY	SEPT 23	Date 2000		City or Town, State AND MARYLAND				
Ball	permit. Peg Department: Important: If eny injury or price.	21. Sonature of Funeral Service Licar	euitt	22. Name and Add MERRITT-A 404 DECAT	DAMS FUNE			YLANO				
	Physician	23a. Part1. Enter the disease, or com shock, or heart failure. List only	0	Do not enter the mode of dy	ring, such as cardie			Approximate Intervel Between Onset and Death				
A.	/Medical Examiner	Immediete Cause (Finel disease or condition	Pancreat		6							
		resulting in death)	Due to (or as									
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× 68760,	ertificate be assected by the second section and section and section and section and section section and section secti	that initieled events resulting in death) Last  Due to (or as a consequence of):										
Bo	e ettence of for us											
o.	ysic	Part II. Other significant conditions of						ntribute to the cause of death?				
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	The law requires tate has been sign page 2 should be Completed by					en autopsy rmed?	24b. Were eutopsy findings available prior to completion of cause of death?					
<u> </u>	certificate has bector, page 2 s					10	Yes 2 No	1 Yes 2 No				
Vitai	certificate rector, pag	25. Wes cese referred to medical examiner?			26. Place of De	eth (Check only o	one)					
5	Z 20 Z	1 Yes 2∏No	Hospital: 1 Inpatient 2 ER	Outpatient 3 DOA	ther: 4 Nursing I	lome 5 Pesi	donos 6 X Oth	er (Specify) Daughter's Home				
ono	ath. r: After the funeral se funeral atlon:	27. Manner of Death  1XX Natural 5 Pending 2 Accident investigation	(Month, Day Year)	b. Tima of lnjury M 1[	ury at ork? ] Yes 2 □ No	28d. Describe	how injury occur	red				
Division	tal or Attending P rs after death. al Director: After t led in by the funera Certification:	3 Suicide 6 Could not be determined	ice 28I. Location (Street and Number or Rurel Route Number, City or Town, State)									
5	To the Hospital or Attending Physician 24 hours after death.  Completely filled in by the funeral completely filled in the filled in t	29e. Certifier Check only one) Certifying Ph	ysician: To the best of my knowled liner: On the basis of examination and manner stated.	dge, death occurred at the end/or investigation, in my	time, date end plece opinion, deeth occu	e, and due to the urred et the time,	cause(s) and me date end place,	enner es stated. and due to the ceuse(s)				
))	Within To the Comp	29b. Signature and title of certifier		29c. Licer	nse number		29d. Date signed (Month, Dey, Year)					
	6	Hung Shale	u Mr).	D 4	6346 SEPTE			EMBER 20 2000				
	, .	30. Neme end address of person who	completed cause of death (Item 23	a) (Type, Print)				A K. B . LEW .				
	This	DR HUMA SHAKIL	625 KENT AVE. C		MARYLAND	21502						
	State	31. Date filed (Month, Dey, Year)	32. Registrar's Signature	loo. V								

Silver to fine to appear

State of Maryland / Department of Health and Mental Hygiene 00 32806

				00	Tunca	te of	Dealli		Re	eg. No.					
Br. Marian	1, Decedent's Name (First, Middle	, Last)	The state of		-11				2. Date of Deat Month	h Day	Year	3. Tima of Death			
Physician /Medical	EDWARD BRENNEMAN HENRY								SEPT.			5:30 AM			
Examiner	4e Fecility Neme (If not Institution, give street end number)						4b. City, To	wn, or Lo	ocation of Death	tion of Death 4c. County of Death					
	10710 OCEAN GAT	EWAY					EA	STON	1			TALBOT			
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs	lest birthdey	) If Unde	Days	If Under Hours	24 Hrs. Min.	8. Dete of Birth	Year)		place (Stete or Foreig			
Director	217-28-2852	1 XM 2□ F	69	Yrs.	MOHITIS	Days	riours	taint,	AUG. 14	, 1931	PENN	SYLVANIA			
	Usuel Residence of Decedent														
ahow ed at	10a. State 10b. County		10c. C	ity, Town or L							1	Od. Inside City Limit			
rector	MD TAI	BOT			EAST(	JN						1 ☐ Yes 2 N			
Director	10e. Street and Number			10f. Zip Code					1	ntry?					
	10710 OCEAN	GATEWAY			1 2	21601				U.S.A	1.				
Funeral	11. Maritel Status		cedent Ever in I	J,S. 13.	Was Dece	edent of Hispanic Origin? (Specify Yes or becify Cuban, Mexican, Puerto Rican, etc.)			ecify Yes or No-		can Indien,				
	1 Never Married 2 Marri	ed 1 XYes	1 XYes 2 No					ricari, etc./		Black, White, etc.					
by	3 ☐ Widowed 4 ☐ Divorced   If Yes, Give Yeer or Detes: 1950-54					AT NO	Specify:			Specify: WHITE					
Completed	15. Decedent	s Educetion	n	16a. Dece	edent's Usi	ual Occup	ation	t of work	ina	16b. Kind of B	usiness/in	dustry			
9	(Specify only highes Elementary/Secondary (0-12)		(Give kind of work done during most of working life. DO NOT use retired)												
E O	11	0	College (1-4or 5+) 0 MACHINI			NIST				TRAILOR FABRICA					
Be C	17. Father's Name (First, Middle, I	ast)					18. Mothe	er's Name	e (First, Middle, I	Maiden Sumer	ne)				
0	JAMES EDWARD H	MES EDWARD HENRY, SR.					MARY	CARN	MEN BREN	NEMAN					
-	19a. Informant's Name/Retationsh	nip (Type, Print)		19b. Mail	ling Addres	s (Street	and Numb	er or Run	al Route Number	, City or Town,	Stete, Zip	Code)			
treum	EMILY T. HENRY/			10710	OCE	AN GA	ATEWAY	Y, EA	ASTON, M	D 2160	L				
other	20a. Method of Disposition		20b.	Place of Disp	osition (Ne	eme of			Dete	20c. Location	- City or To	own, Stete			
ō	1 Burtal 2 Cremation		State	cemetery, cre					11/12000	CODI	20174	MD			
and injury	4 Donation 5 Other (Sp		ST	PAUL'					0/4/2000	CURI	OOVA,	MD			
DUC	21. Signature of Funeral Service I	icensee	TITS	I I	ELLO	WS . 1	ss of Faciti HELFE	NBEI1	N, & NEW	NAM FU	NERAL	HOME,			
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	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea	ith. Do not en	nter the mo	de of dyin	ng, such as	cardiac	or respiratory arr	est,		Approximate Interval Between			
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EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.														
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page 2 should									performed? availa		vailable prior to emptetion of ceuse				
nple						1			1111			death?			
Com									1 🗆 Y	es 2 X No	1	☐ Yes 2☐ No			
Be C	25. Was cese referred to medicel examiner?			11-11-11			26. Plac	e of Deat	eath (Check only one)						
I director,	1 ☐ Yes 2X No	Hospitel:	Inpatient 2	☐ ER/Outpatie	ent 3 🗆 D	ON ON	Other: 4 Nursing Home 5 AResidence 6 Other (Specify)					ity)			
	27. Manner of Death	Manner of Death 28a. Date of Injury 28b. Time of							28d. Describe h	ow injury occu	rred				
3 0	7. Manner of Death 1. Natural 5 Pending investigation 3 Suicide 6 Could not be determined 28e. Place of Injury At home, farm, street, factory,						Yes 2	No	lo						
0 #									28f. Location (Street and Number or Rurel Route Number City or Town, Stete)						
oy the t		buil	ding, etc. (Spec	ify)					City or Tow	n, Stete)					
d in by the fa	4 Homicide determine														
filled in by the funera	4 Homicide determ	Physician: To th	29a. Certifier  (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)												
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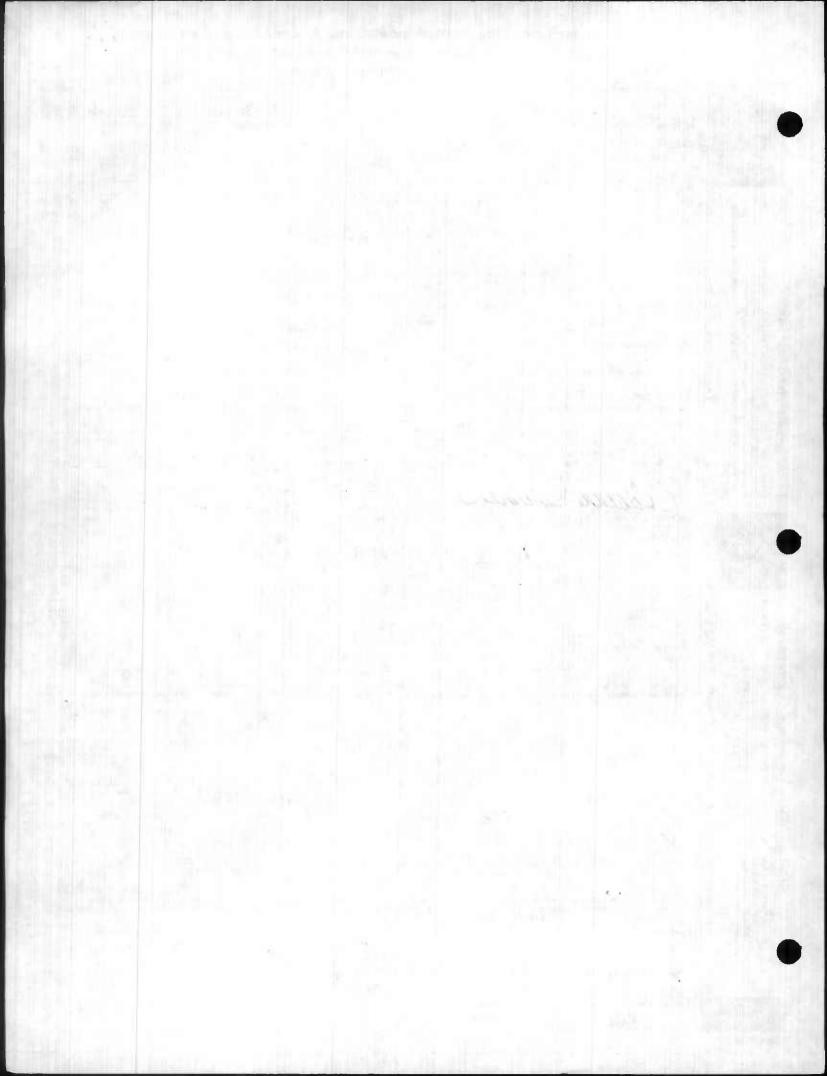


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State of Maryland / Department of Health and Mental Hygiene

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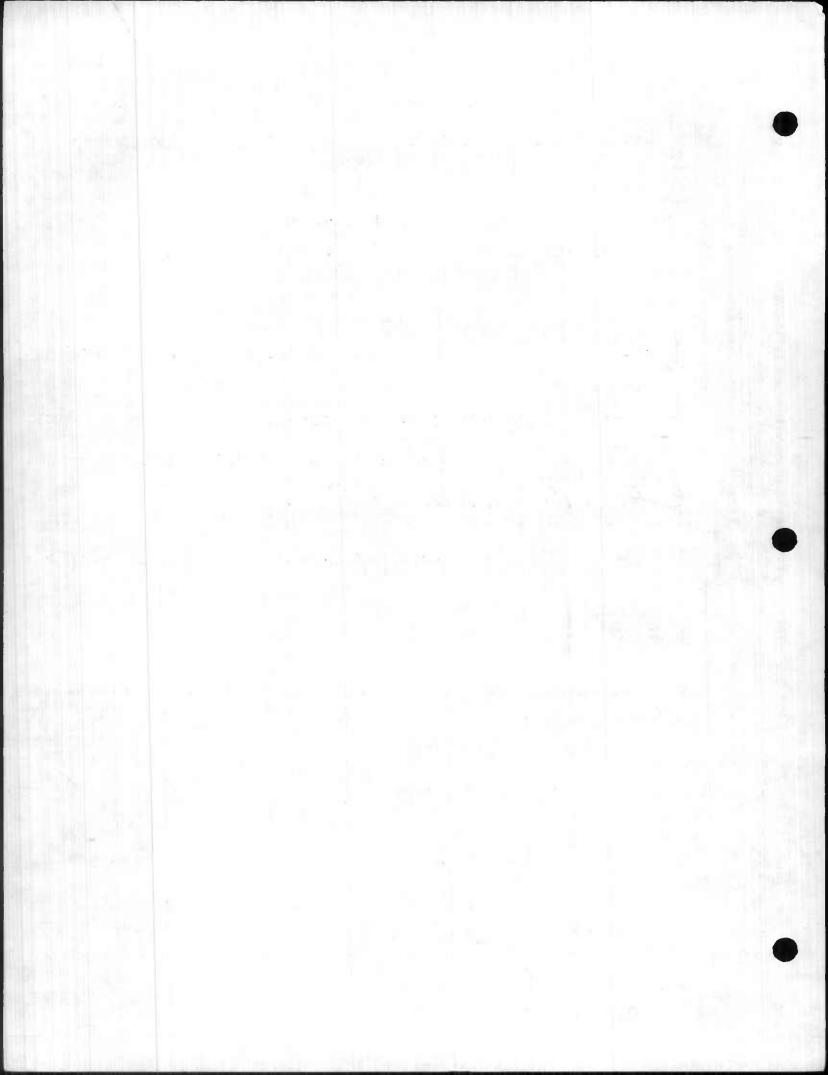
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					tist Hosp					Takoma		-	Montg	omery	,	
	Funeral		Social Security No	T	ex 7. A	ga (fn yrs. fa	st birthday, Yrs.	Months	Days	If Under 2 Hours	Min.	8. Data of Birt (Month, Da)	v, Year)	Coun	lace (Stata o	or Foreign
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	or 28s-1 a	100	a. Street and Num			Tall	.s Cill		p Code				10g. Citizan of V	Vhat Coun	try?	
	th with the state of the state		113 West	cott Stre	et :			2	2042				USA			
	9 25	11.	Marital Status		12. Was Decedent		3. 13.	Was Dece	dant of h	lispanic Orig	in? (Spec	cify Yas or No	14. Rac	e - Amaric		
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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 32808 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Year **Physician** ERNESTINE RICKS HOWELL SEPT. 30, 2000 5:15 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Mariner Health of Kensington Kensington MONTGOMERY If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 20 F 578-07-0144 90 Director Sept. 27, 1910 Maryland **Usual Residence of Decedent** the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow Pages 1 and 2 should be filed within 72 hours after deeth with the Maryles nent of Health and Mentel Hyglene.
Int: If Itam 27 is marked other then "natural", or thems 23s or 28s-f above uty or other treumatic event, the Medical Examinar must be notified. 1 Yas 2 No Director N/A Washington, DC 10f. Zip Code 10c. Citizen of What Country? 10e Street and Number 5721 6th Street, NW 20011 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify Black à 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Second condary (0-12) College (1-4or 5+) Dental Assistant Dental Services Baitimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 8 Ernest Ricks Emma Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joyce Ricks Dennis (Niece) 5721 6th Street, NW, Washington, DC 20011 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Depertment of Important: If any Injury or page. Pleasant View Cem. 4 ☐ Donation 5 ☐ Other (Specify) 10/5/00 Gaithersburg, MD 21. Senatura of Funeral Service License 22. Nama and Address of Facility SNOWDEN FUNERAL HOME ROCKVILLE, MD 20850 ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician tmmediate Cause (Finet disease or condition resulting in death) /Medical YES Examiner Due to (or es a consequence) Examiner LOSCLE /cerdious sician end burlal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) physician sthe burlal Box 68760, Physician/Medical Due to (or es e consequence of): attending p signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. Completed by 24b. Were sutopsy findings evailable prior to completion of cause of death? 24a. Wes an eutopsy performed? widist 2 X No 1 Yes No certificata 1 ☐ Yes Division of Vital or Attanding Physician: director. 25. Wes case referred to medical examiner? 8 26. Place of Deeth (Check only one) 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Natural 5 Pending deeth. 1 Yes 2 No investigation 2 ☐ Accident after deeth Director: 3 ☐ Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide ne Hospital or J n 24 hours after ne Funeral Dire pletely filled in b 29a. Certifier edical 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. To the Hosp within 24 hos To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D00023275 October 3, 2000 (20 Dohna Hendin, mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3309 Shere wheaten mo eld Road 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 5 2000

**DHMH 16 Rev 6/95** 

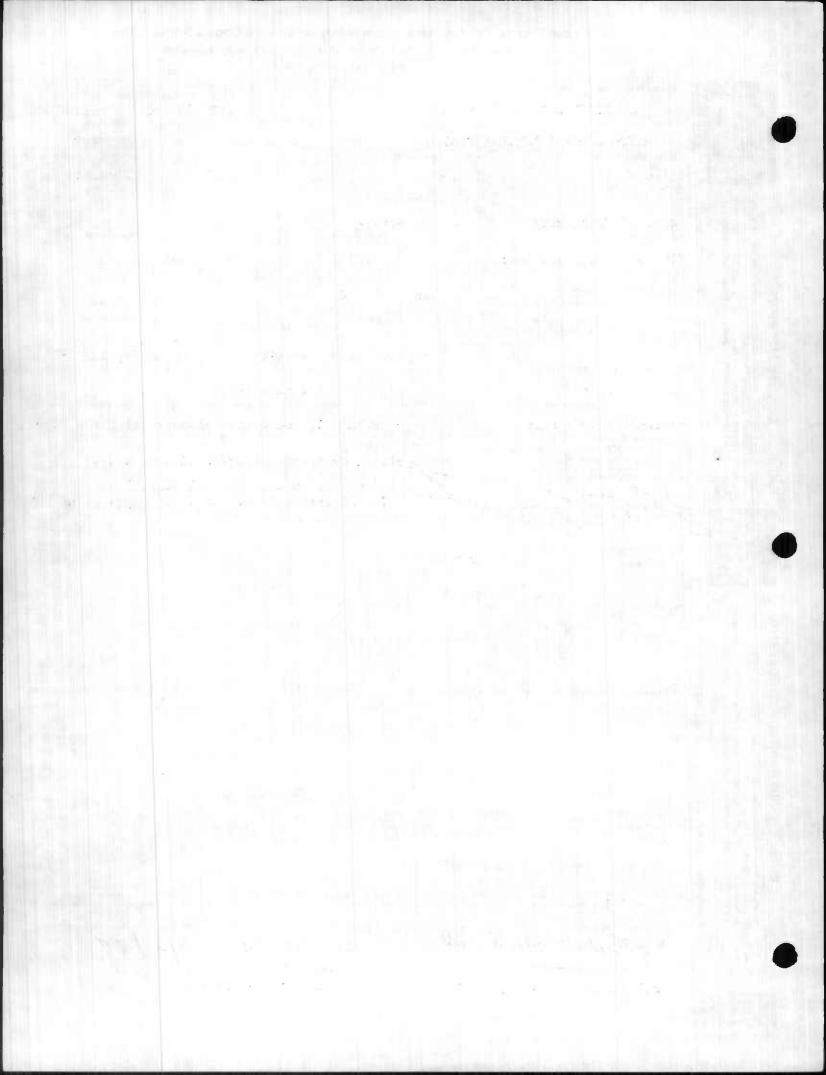


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State of Maryland / Department of Health and Mental Hygiene 00 32809

Certificate of Death

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ŀ	Funeral Director		cial Security N	Number 6	S. Sex	7. Age (In y	rs. lest birtl	hdey)_ 'rs.	If Under	er 1 Year Deys	If Under		8. Date of B (Month, D	irth ley, Year)			tete or Foreign
			I Residence o			4	, 0						OCC 7	1/21	ATT	RTIIT	3.
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	omple of the		Signature end	title of certifier	(1)		1		2	9c. Licen	se number			29d. Date	signed (Mon	th, Day, Ye	ear)
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			M.M.P	ERELLO,	LT, MC.	USNR							20889				
	State	31. D		oth Day Year)		Registrar's Si	ignature	4	1	- 1	,						

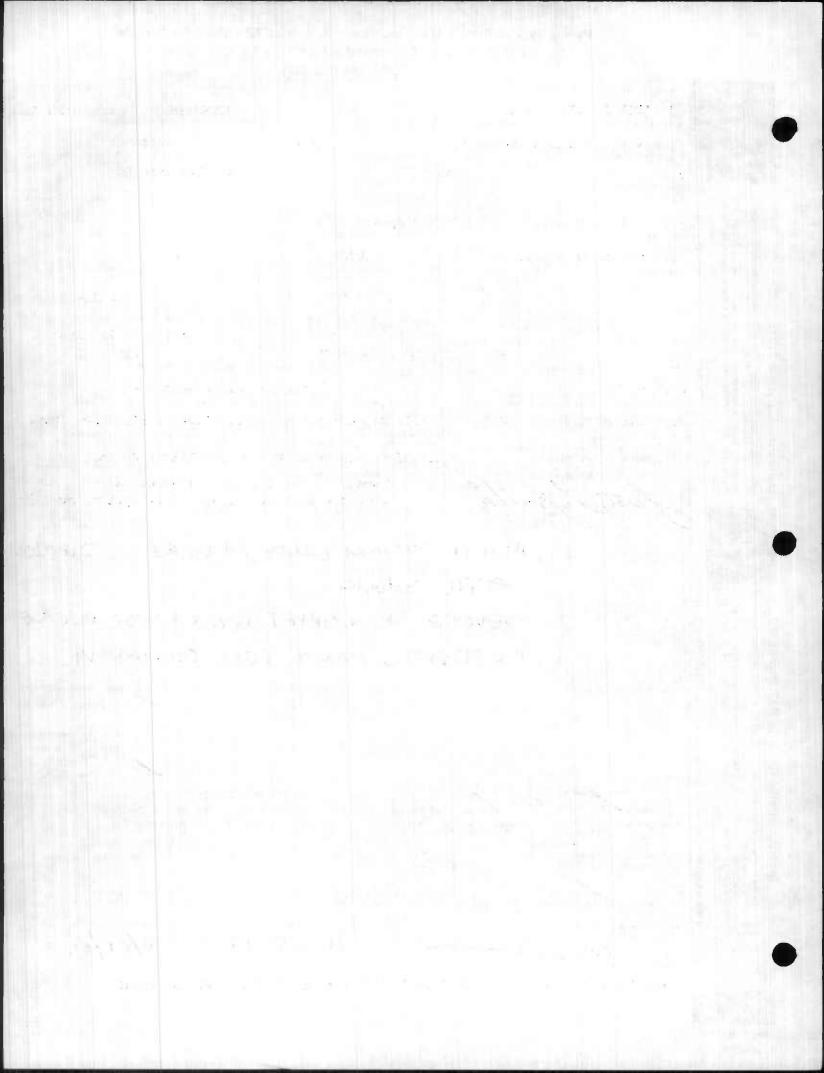


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Death Dey Month **Physician** TERENCE JOSEPH HERRON SEPTEMBER 30, 200 ation of Deeth 4c. County of Deeth 2000 10:20 PM /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner Montgomery Bethesda National Institute of Health If Under 24 Hrs Hours Min. If Under 1 Year 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) 5. Sociei Security Number Birthplace (State or Foreign Country) **Funeral** Months Deys 1 □XM 2 □ F 50 June 22, 1950 DC Director 213-56-2311 Usual Residence of Decedent the Marylend 10c. City, Town or Location 10e State 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Missign Example: must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 20902 1811 Belvedere Boulevard IISA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ∑ No If Yes, Give Yeer or Detes: 14. Race - American Indien, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus Black, White, etc. 1 Never Merried 2 Merried 1□ Yes 2 No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education
(Specify only highest grade completed) National Institute Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 5+ Budget Analyst of Health other 17 Fether's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be filk Department of Health end Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event Be John M. Herron Margaret Ellen McAndrew 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Patricia Ann Herron / Wife 1811 Belvedere Boulevard, Silver Spring, MD 20902 Baltimore, 20b. Placa of Disposition (Neme of cemetery, cremefory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ABurial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 10/4/00 Silver Spring, MD 22. Name end Address of Fecility
Francis J. Collins Funeral Home, Inc. 21 Signature of Funeral Service Licenses 500 University Blvd., W, Silver Spring, MD 20901 ons that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, ause on each line. Approximate Interval Between Onset end Deeth **Physician** MULTI- SYSTEM ORGAN FAILURE /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or es e consequenca of):
SENTIC SHOUL Examiner physician and s the burial-trens Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last certificete be exec ERE SICIN GRAFT VERSUS HOST PISEASE
Due to (or es e consequence of): P.O. Box 68760 Physician/Medical VATIC RENAL CELL GREINDMA 80 USB 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? page 2 1 ☐ Yes 2 PINO 1 ☐ Yes 2 ☐ No Attending Physician: funeral director, 25. Was case referred to medical Be 26. Piece of Deeth (Check only one) Hospitel: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 10 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Yeer) Certification: 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 DNeturei 5 Pending s efter death. 1 Yes 2 No Investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ò 24 hours 29a. Certifier i 👺 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the ceuse(s) end menner es stated. Medical 2 Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 39 111-9617 00 10 30. Name end eddless of person who completed cause of deeth (Item 23e) (Type, Print) SAMEENA KHAN, M.D. 9000 ROCKVILLE PIKE BETHESDA, MARYLAND 20892 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State OCT 0 2 2000 Registrar



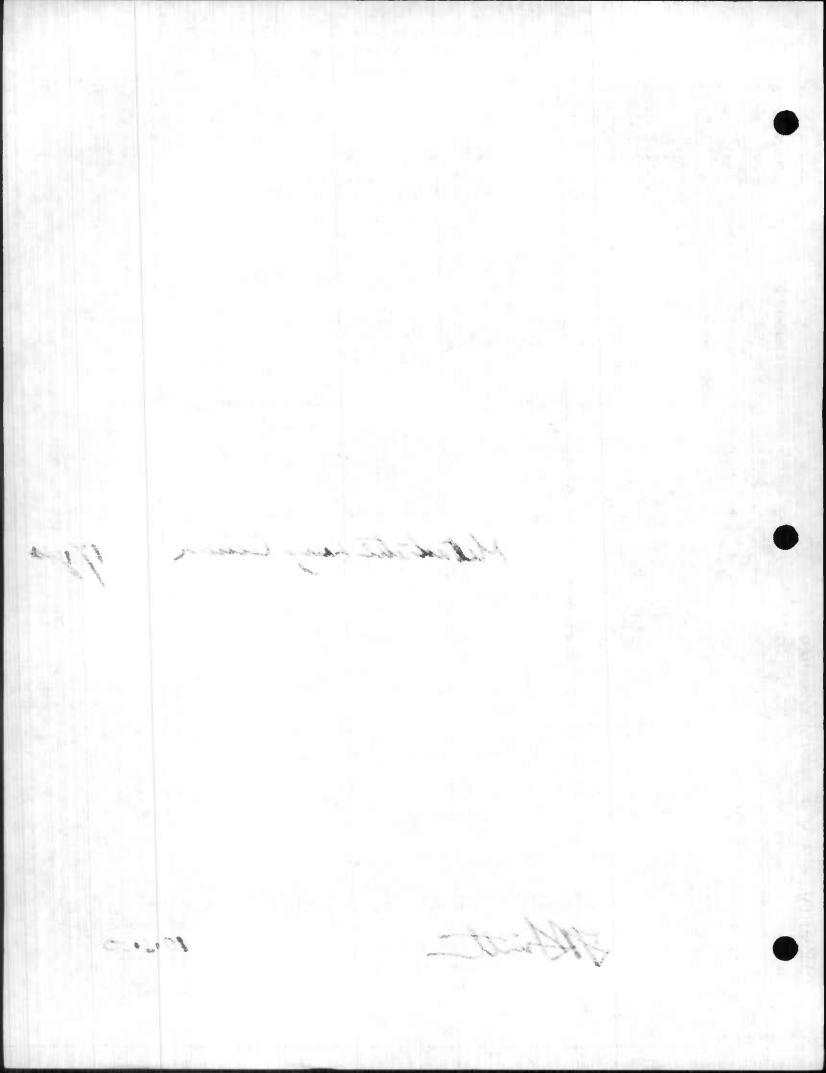
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State of Maryland / Department of Health and Mental Hygiene

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32811

						C	ertifica	ate of	Death		Reg. No.				
	Physician /Medica	Decedent's Nar	na (First, Middle		Mary J.	Haw1	ey			2. Data of D Montb Octobe		) O <sup>Year</sup>	3. Time of Death 10:00 AM		
	Examiner	STATE OF THE PARTY		n, give street and n	number)				4b. City, Town, or	Location of Dea	th 4c. County	of Death			
	4 14 A	Subur	ban Hos	spital					Bethesd			gomer	d		
	Funeral	5. Social Security		6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs		Month	der 1 Yaar s Days	If Undar 24 Hrs Hours Min.	(Month, D	rth ay, Year)	9. Birthpl Count	aca (Stete or Foreign try)		
	Director	384-20-6		10 101 241	7	3 Yrs.				October	10, 1926		Michigan		
	pu k	Usual Residenca	10b. County		10c. C	ity, Town or	Location				30.7	10	Od. Inside City Limits		
	Many day	Maryland	Monte	gomery	P	otoma							1 ☐ Yes 2 🗓 No		
	vith the Ma	10e. Street and No	1	Joiner y		o coma (		Zip Code			10g. Citizen of \	What Count	trv?		
	th with the Marylands 23a or 28a-1 ahow unt be notified at	88		Spring	Road			208	54		Unite				
	72 hours after deeth with the Maryland natural; or hams 23s or 28s4 show deal Examine must be notified as about hy Estheral Director	11. Marital Status				U.S. 1	3. Was Dec		Hispanic Origin? (S an, Mexican, Puer	pecify Yes or N		e - America			
0	Her her	1 Never Mai	ried 2 Marr	ied 1 ☐ Yes	ecedent Ever in I Forces? s 2 No					lo Rican, atc.)	Blac	ck, White, e			
020	urs aft	3 🖾 Widowed	4 Divorced	If Yas, C Year or	Give Dates:		1 ☐ Yes	2 No	Specify:		Specify	v: Wn	ite		
Maryland 21215-0020	natural, olea Ex	10-11	15. Deceden	t's Education	.0	16a. De	cedent's Us	sual Occup	pation	dina	16b. Kind of B	usiness/Ind	lustry		
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Pu	should be filed within 72 ho and Mental Hygiene. I marked other than "natur umatic avant, the Mischell To Re Commisted	17. Fathar's Name	(First, Middle,	Last)					18. Mother's Nar	ame (First, Middle, Maiden Sumeme)					
la	should be nd Mental marked o urmatic ave	Emi1	io More	11i					Ann	a Zimei					
an	s 1 and 2 should be filed. Health and Mental Hyg tem 27 is merked other other traumatic avant,	19a. Informant's I	Name/Relations	hip (Type, Print)		19b. Ma	alling Addre	ess (Street	end Number or Ru	rei Route Numi	ber, City or Town,	State, Zip	Code)		
	and salth	Margare	t L. Ha	wley/Dau					Avenue,	Chevy (	Chase, M.	aryla	nd 20815		
ore	of He	20a. Method of Di		3 Removal from	20b.	Piace of Dis	sposition (A	leme of r other ple	ce)	October	20c. Location -	City or To	wn, State		
Ē	Pege Prese		5 Other (S		St	. Mar	y's C	emete	ry	6, 2000 Rockville, Maryland					
Baltimore,	permit. Pages 1 and 2 sho Department of Health and Important: If Item 27 is ma any injury or other trauma	21. Signature of F	inghi Spyson	Licensee		T	22. Name	and Addre	ass of Facility		/Pooleri 11.	Tno			
m	88 5 8	Mic	Robert A. Pumphrey Funeral Home/Rockville, 300 West Montgomery Avenue, Rockville, Mary												
		23a Party Enter	M00846 300 West Montgomery Avenue, Rockville, Mar												
	Physician	snock, or ne	art failure. List	only one wantle on	each line.	. ,		,		_		- !	Onset and Death		
	/Medical	immediate Cause	(Final		Med	not:	:1/1		ung (	and	u	1	14.14		
	Examiner	disease or conditi resulting in deeth	on	a	Due to				7			1	1 year		
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- 0	en a urial-t	Sequentially list of any, leading to cause. Enter Unc Cause (Disease of that initiated even	mmediate lerlying												
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2 %	the atter	Part II. Other sign	ificant conditio	ns contributing to	death but not re	sulting in the	e underlying	g cause giv	ven in Part I.	23b. Did	l tobacco use co	ntribute to	the cause of death?		
P.O.	to you t									10	Yes 2□ No	3 Prob	bably 41 Unknown		
	Se de de											T			
Vital Records,	The law requires rate has been sign page 2 should be	24000								24a. Wa	s an autopsy formed?	ave	ere autopsy findings silable prior to		
2 00	law response be so shown					100	-					of c	mpletion of cause death?		
- E	The lav									1□	Yes 2 No	10	Yas 2□ No		
ita	certificate rector, page Co	25. Was case refe	erred to medical						26. Place of De	ath (Check only	one)				
> >	2 00	examiner?	) No	Hospital:	Inpatient 2	☐ ER/Outpat	tient 3	DOA Oth	her:		sidenca 6 Oth	ner (Specify	v)		
INCAP Ly	는 도를	27. Manner of Dea		28a. Det	e of Injury onth, Dey Year)	28b. Time		28c. fnju	ry at	28d. Describe	how injury occur	red	765.006		
रे ह	Attending Ir deeth. sctor: After by the fune	1 Neturel 2 Accident	5 Pendin investig		mui, Day i saij	irijui	M	1 🗆	Yes 2□No	200					
Division of	or Attend efter death Director: /	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)									(Street and Numi	ber or Rure	l Route Number,		
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2	Hospital 24 hours e Funeral [ letely filled	29e. Certifier  126 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
3	To the Hospital Within 24 hours To the Funeral completely filled										, date and place,	and due to	me cause(s)		
7_	To the Comp	29b. Signature and title of confidence						29c. Licens			29d. Date signe				
3	15	D33293							10.3	.00					
L	13	30. Nama and address of berson who completed cause of death (Item 23a) (Type, Print)													
				ith, M.D				venue	NW. Was	shington	DC 20	015-2	998		
	State	31. Date filed (Mo			Registrar's Sign		211	/	, ATTI HOL	JIIII EUI	20 20	013-6	,,,,		
	State	(	OCT O A	2000	DRIVERPER	14	A	sa N	21						



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State of Maryland / Department of Health and Mental Hygiene [ ]

3281 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year **Physician** Garmon, Hawkins 4:07 pm October une 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Baltimore City HospHal University of Mansland # Under 1 Year | # Under 24 Hrs. | 8. Date of Birth | 9. Birthpusca (Country) | Months | Days | Hours | Min. | (Months Day Year) | North Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** 10 M 20 F 93 Director 241-09-7613 Usual Residenca of Decedent 10d. Inside City Limits 10a State 10c City Town or Location 10b. Counts 1 Yes 2 □ No MD Baltimore Directo is merked other than "natural", or literie 23s or 28s f traumatic svent, the Medical Examiner mast be notifie 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? Norne 23a 1601 E. Belvedere Ave 21239 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No It Yes, Give X Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ➡ No Specify: þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) permit. Pages 1 and 2 should be filled within 72. Department of Health and Mental Phylanol. Importants if them 27 is marked other than "natulary finluty or other traumatic event, the Medical phose. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Used Car Dealer Whitlock Motors 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 96 John Benjamin Hawkins Florence Elizabeth Dellinger 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21206
Dete | 20c. Location - City or Town, State Judith L. Mehrling / daughter 5126 Hillburn Ave 20b. Placa of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory, Inc. 10/6/00 Beltsville, MD 22. Name and Address of Facility CAFA Stephen D. LOhrmann, P.A. hter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, or heart failure. List only one cause on each line. Towson, MD 21286 Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final diseasa or condition resulting in death) /Medical Pneumonia Examiner Dua to (or as a consequence of) Physician/Medical Examiner yrosepsis ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (of as a consaguanca of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence ot): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by the 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Wera autopsy findings evailable prior to completion of cause of death? been signature Completed 24a. Was an autopsy page 2 s 2 ZINO 1 Yes 1 ☐ Yes 2 ☐ No certificate Physician: Be 25. Was casa ratarred to medical 26. Place of Death (Check only ona) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? i or Attending Patter death. 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 ☐ HomicIde To the Hospital o within 24 hours aft To the Funeral Di Completely filled in Certifying Phyeician: To the best of my knowledga, daath occurred at tha tima, data and place, and due to the cause(s) and manner as stated.

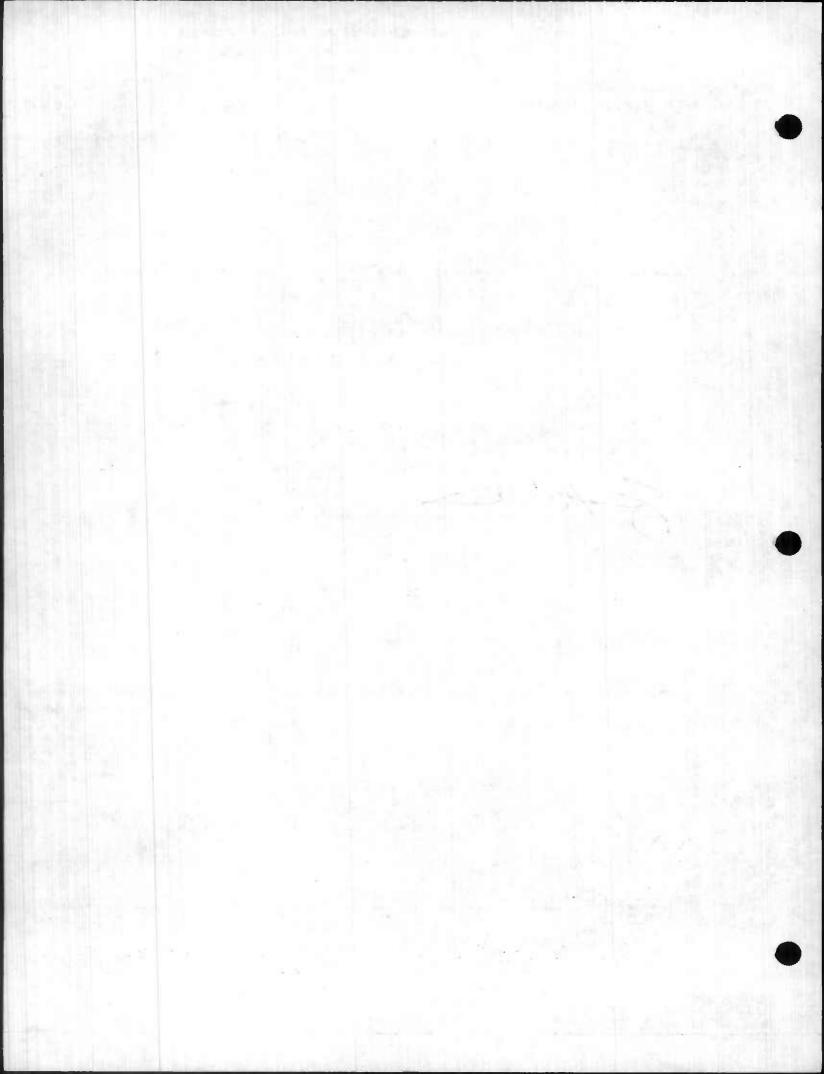
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to the cause(s) and manner stated. 29a, Certifier edicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifies P12434 October One, 2000 Munno 30. Nama and addrass of person wto complated causa of death (Itam 23a) (Type, Print) 3, oreene street Shelka Lemale-Williams, MD

11 Date tiled (Month, Day, Year) 32. Registrar's Signatura Baltimore Maryland 2120 State OCT 0 5 2000

Registrar

**DHMH 16 Rev 6/95** 

**ORIGINAL** 



## Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey ひろ Month Year 420 10 2000 4a Facility Name (If not institution, give street and number) Happe 4b. City, Town, or Location of Death 4c. County of Deeth Hospita JUEN 9. Birthplece (Stete or Foleign 5. Social Security Number 6 6. Sex 7. A If Under 24 Hrs. 8. Dete of Birth Month, Day, Ye MARCH 20, If Under 1 Year 7. Age (In yrs. last birthday) Year 1910 Months Deys WISCONSIN 90 471 01 4913 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MONTGOMERY SILVER SPRING 1 ☐ Yes 2 ☐ No 10e. Street end Number 10f. Zin Code 10g. Citizen of Whet Country? 20906 USA 3576 GLENN EAGLES DRIVE Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, 11. Meritel Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes: Bleck. White, etc. 1 Never Married 2 Married WHITE 1 Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) MALTING SHEET METAL WORKER 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) KATE BOLLAND EDWARD HAPPE 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) MILDRED HAPPE (SPOUSE) 3576 GLENN EAGLES DRIVE SILVER SPRING, MD 20906 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2X Cremetion 3 Removel from State 10-5-00 BRENTWOOD, MARYLAND 4 Donetion 5 Other (Specify) FORT LINCOLN CREMATORY 21. Signature of Faneral Service Licensee 22. Name end Address of FeciliMINES-RINALDI 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Ceuse (Final disease or condition resulting in deeth) Depsis IWK Due to (or es a consequence of). nemous Eng. Due to (or es e consequence of) Chemic Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown NA 24b. Were autopsy findings evailable prior to completion of ceuse of deeth? 24a. Was en eutopsy performed?

**Physician** /Medical Examiner

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Box 68760.

P.0.

Division of Vital Records,

or Attending Physician:

**Physician** 

/Medical

Examiner

10a. Stete

MD

Directo

Funeral

þ

Completed

**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Moorest Examinal mark by notified at

permit Pages 1 and 2 should be tiled within 7 Department of Health and Mantal Hygiene. Integral mit if item 27 is marked other than "new Injury or other traumatic event, it a Man annew.

with the Maryland

72 hours after death

Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in deeth) Lest Physician/Medical

26. Place of Deeth (Check only one)

1 Yes 2 No

25. Wes cese referred to medical exeminer? 1 Yes 2 No

Hospital: 2 ER/Outpetient 3 DOA 1 Dippatient 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Yes

2 No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

27. Menner of Deeth 5 Pending 1 Netural investigetion 2 Accident

28e. Dete of Injury (Month, Dey Yeer)

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29a. Certifier

3 Sulcide

4 Homicide

(Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner as steted.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner stated. 29d Date signed (Month, Day, Year)

29b. Signature end title of certifier

150926 Pamela Wright, M.D.

29c. License number

10 2000

30. Name end eddress of person who completed cause of doubt (Item 23e) (Type, Print) Brive 1 DISKNED IN Center 5

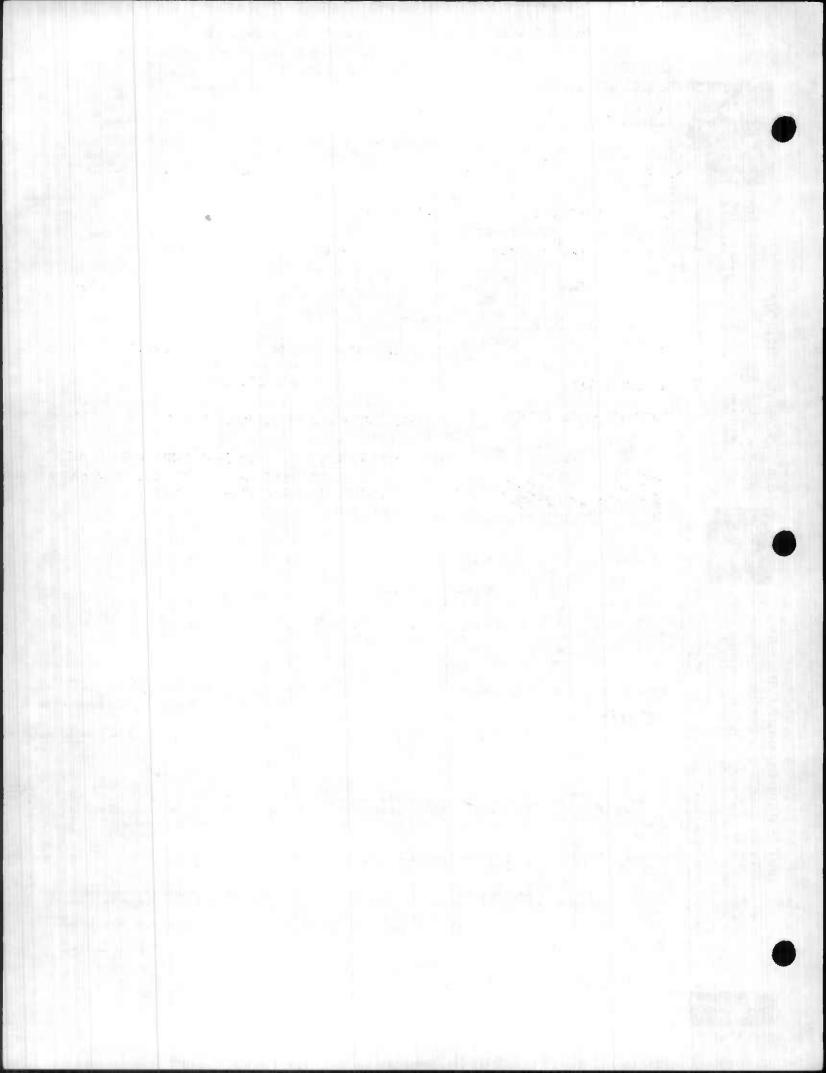
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31. Dete filed (Month, Day, Year) 2000 5 oc

6 Could not be determined

32. Régistrar's Signeture

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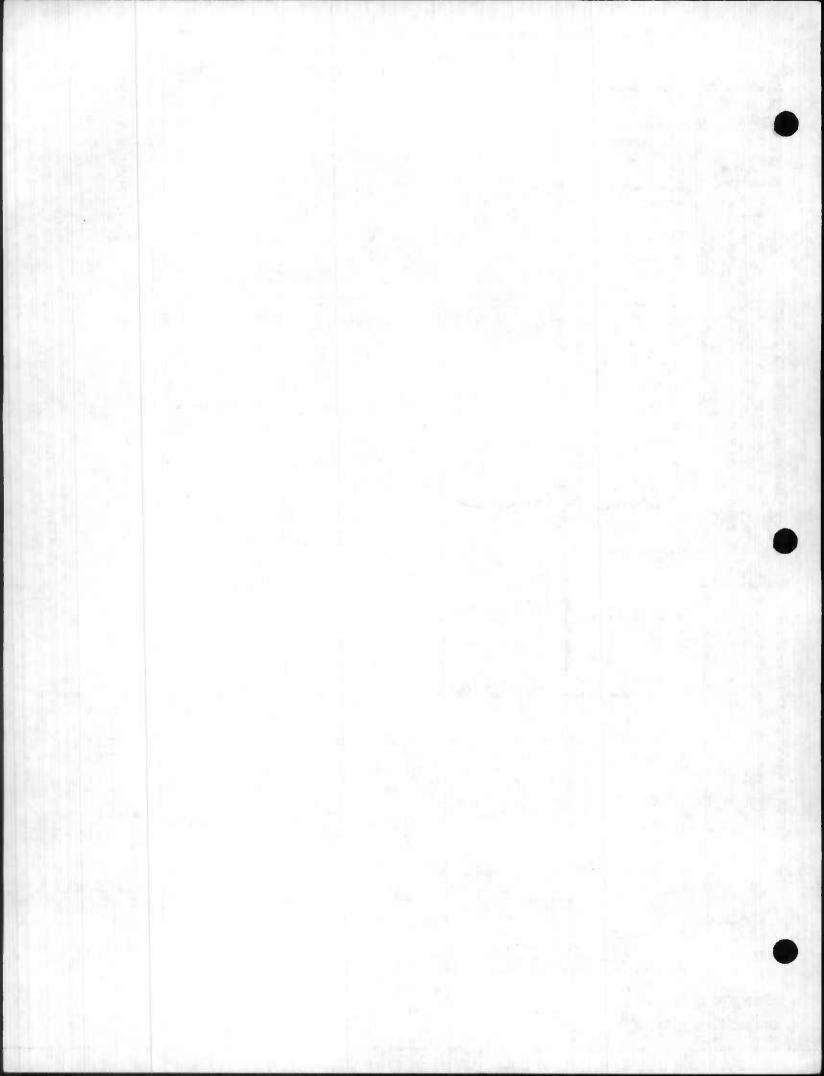
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State of Maryland / Department of Health and Mental Hygiene

32814

					Ceni	ticate o	Deatr	7		Reg. No.			
1. Decedent's Name	e (First, Middle, Li	est)							2. Data of Do	eath Dey	Yaar	3. Time o	f Death
Robert	Janu	ary							Oct. 2	2, 2000	1 001	3:57	AM
4e Facility Name (/	f not institution, gi	va street end nu	um <i>ber)</i>			17 11-1-	4b. City, T	own, or L	ocation of Dee	th 4c. County	of Deeth		
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Usuel Residence of										,	Doar	Diana	
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19e. Informent's Na	me/Relationship	(Type, Print)		19b.	Meiling.	Address (Stre	et end Numi	ber or Rui	al Route Numi	ber, City or Town	, Stete, Zip	Code)	
Gwendol'	yn L. The	omas -	Cousi	n 39	02 D	aphne,	Hous	ston,	Texas	77021			
20e. Method of Disp					Disposit	ion (Neme of tory or other p			Dete	20c. Location	- City or To	wn, Stete	
	□Cremetion 3 [		n Stete					1	0/6/00	Suitlan	d Ma	rvlar	d
. Zostata Centar (Spesify)												Lylan	.u
McGuire Funeral Service, Inc.													
7400 Georgia Ave. N.W., Washington, D.C. 200 23e. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast,  Approximate													20012
diseese or condition resulting in death)  Sequantielly list continues the cause. Enter Under Cause (Disease or that Initiated events resulting in death) I	nditions, imadiate ortying injury	e	Due	to (or as a co	onseque	enca of):	vascu.	Id!	)isease			years	•
Pert II. Other signif			death but no	ot resulting in	the unde	erlying cause	given in Part	11.		tobacco usa co			of death
Cancero	us Esoph	agus											
										s an eutopsy formed?	COL	ara autopsy ailable prior mpletion of daeth?	to
									1□	Yes 2X No	10	Yes 2	] No
25. Was case refer	red to medical						26 Plac	ce of Dea	th (Check only				
examiner?		Hospitel:	Inpatient	2 ☐ ER/Out	nations	3□ DOA				sidenca 8 🗆 Oti	har (Snacik	()	
27. Menner of Death 1 Naturel 5 Pending investigation 3 Suicide 4 Homicida 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28a. Place of Injury - At homa, farm, streat, factory, of building, etc. (Specify)								No		how injury occu		7	3 %
3 ☐ Suicide 4 ☐ Homicida	6 Could not l datarmined	4 28a. Plec	ce of Injury - ding, etc. (S	At homa, far specify)	m, straa	t, factory, offic	<b>&gt;</b> 9			(Streat end Num own, Stata)	ber or Rure	l Route Nu	m <i>ber</i> ,
29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the causa(s) and manner as (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the causa(s) and manner as due and manner stetad.												(s)	
							ense number			29d. Date signe	ed (Month,	Dey, Year)	
00 00 (10.1)						0.53			0-1-1	2 0	000		
11	mel	end	W.	~			852			October	3, 2	000	
30. Name and addrass of person who completed cause of death (Item 23e) (Type, Print)													
	DeVore,	M.D.	4203	Queens	bury	Road,	Hyati	tsvil	le, Ma	ryland	20781		
31. Deta filed (Mon.			Degistrer's		4	book	1.						
U	CT 062	000	Prev-	6	1.	DOUN	2						

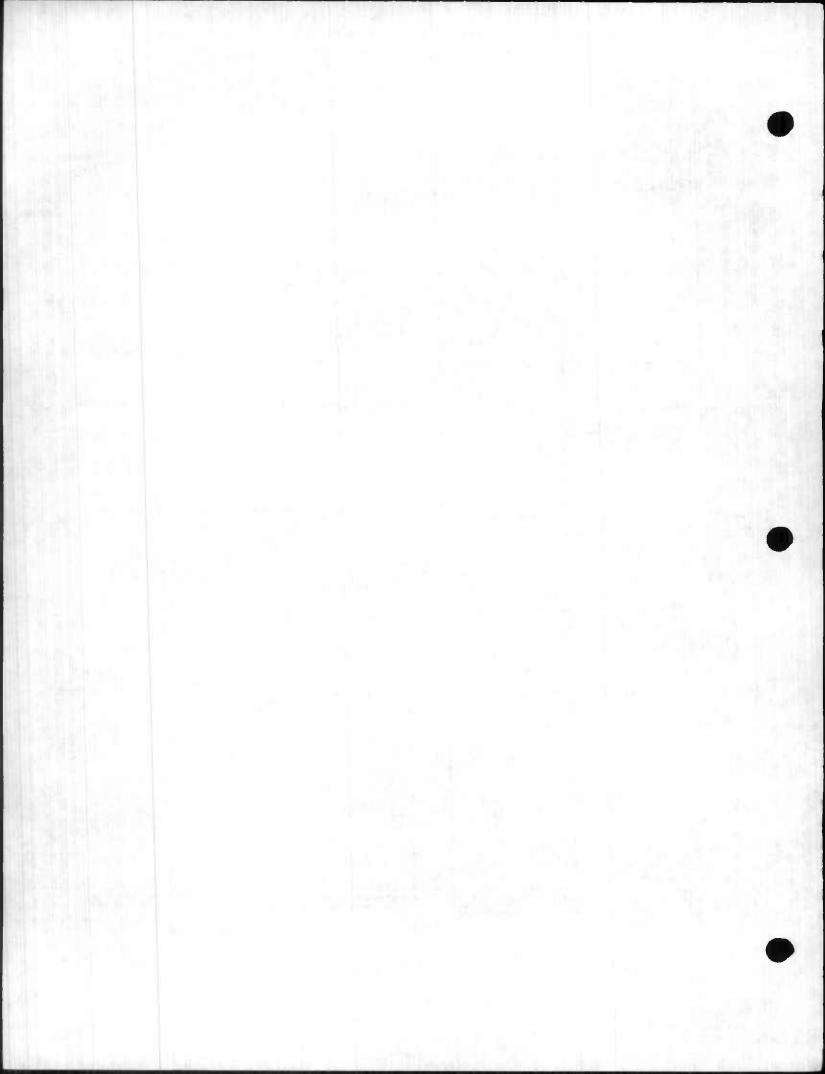
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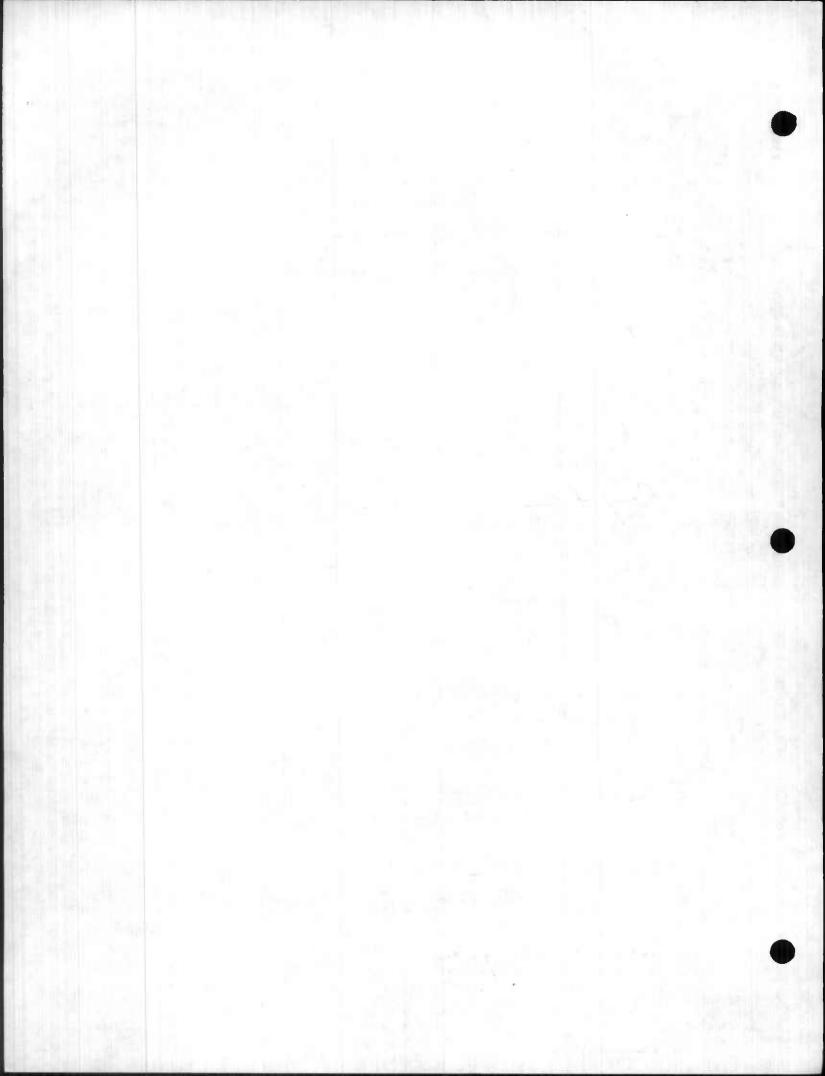
			C	ertificate	of i	Death			Reg. No.			
	1. Decedent's Name (First, Middle, L	est)						2. Date of De		· · ·	3. Time of Death	
Physician	Minnie E. Kuzem	ka						Month	29, 2000	Year	3:30 PM	
/Medical	4a Facility Name (If not institution, gi				-	4b. City, To	wn, or Lo	cation of Deal		y of Death	0.00	
Examiner						Silve	w Cn	nina	Mont	tgome	w37	
	706 Notley Rd 5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last birthda	If Under		If Under		8 Date of Bi	rth	9 Birthr	place (State or Foreign	
Funeral Director	236-28-9255	1□ M 2□XF	77 Yrs.	Months	Days	Hours	Min.	(Month, Di	ay, Year)	Cour	Virginia	
Director	Usual Residence of Decedent		,,					may 1.	3, 1723	West	VILGINIA	
E 8 10	10a. State 10b. County		10c. City, Town or	Location						1	10d. Inside City Limits	
Mary De de	Maryland Montg		Cilvon	Comina							1 ☐ Yes 2 No	
with the Marylan t or 28a-f show be notified at Director	Maryland Montg	omery	Silver	10f. Zip	Code				10g. Citizen of	What Cour	niry?	
2 2 0						,					,	
ath w	706 Notley Rd	140 1111 1111	5 - 1 - 1 - 1 - 1 - 1		090		-1-0 10	-16 - 1/ 14	USA	ca - Americ	one Indian	
ner death v r herre 23s siner must	11. Marital Status	12. Was Decedent Armed Forces?		<ol><li>Was Decede If Yes, speci</li></ol>	ify Cuba	an, Mexicai	n, Puerto I	Rican, etc.)		ack, White,		
D20	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 XI	No	1□ Yes 2	No No	Specify:			Speci	fy:		
d b		Year or Dates:							100 100 100		hite	
1 21215-0020 ind within 72 hours at bygers. Agricult the Medical Exam to the Medical Exam Completed by I	15. Decedent's E (Specify only highest g	ducation rade completed)	16a. De	cedent's Usual ive kind of work b. DO NOT use	k done	ation during mos	t of working	ng	16b. Kind of E			
The state of	Elementary/Secondary (0-12)	College (1-4or 5	5+)			2)			Depart			
Co Apple O	12			Secreta	ry	40.04.0		45° 4 10° 40°	Agricu		e	
B state e	17. Falher's Name (First, Middle, Las								, Maiden Suma	me)		
ylar Menta Menta Mice To E	Erminio Mariott	í				Nat	alin	a Poli	ca			
Maryland d 2 should be file th and Mental Hy T is marked othe traumetic event. To Be C	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	ailing Address	(Street	and Numb	er or Rura	I Route Numb	ber, City or Town	, State, Zip	Code)	
	Alex W. Kuzemka	/Son	706	Notley	Rd	, Sil	ver	Spring	, MD 209	904		
or Heart Heart Heart Heart Cother	20a. Method of Disposition		20b. Place of Dis	sposition (Namerematory or other	e of her place	ce)		Date	20c. Location	- City or To	own, State	
Baltimore, went Pages 1 a went Pages 1 a went of Hea moortant if Item iny Injury or othe	1  Burial 2  Cremation 3  4  Donation 5  Other (Spec			f Heave			rv	Oct 2	Silver	Spri	ng, MD	
alti minimi	21. Signature of Funeral Service Lice	onsee							aldi Fur	neral	Home	
m ada a	1 00000	Oserma 1							g, MD 20904			
	200 200 50000				100		100			-		
	23a. Part1. Enter the disease, or cor shock, or heart failure. List only	y one cause on each li	ne.	anter the mode	or dyn	ig, such as	Cardiac o	i respiratory o	211031,		Approximate Interval Between Onset and Death	
Physician /Medical	Immediate Course /Final											
Examiner	Immediate Cause (Final disease or condition resulting in death)  Urosepsis											
and the same of th			Due to (or as a consequence of):									
od sit		Mu]	Ltiple Sc	Lerosis						14	21 years	
68760, ifficate be executed g physician and as the burial-transit tedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (or as a con:	sequence of):								
68760, ifficate be ext g physician as the burial.	Cause (Disease or Injury	C										
. Box 68760, death certificate be execut e attending physicien and of for use as the burial-tran-	that initiated events resulting in death) Last		Due to (or as a cons	sequence of):								
× 5 50 2		4										
P.O. Box let the death cer d by the attendin letached for use Physician/A	E Made OF TRANSPORT									1		
O. I of the a the a hed f	Part II. Other eignificant conditions	contributing to death b	ut not resulting in the	e underlying ca	use giv	en in Part	l	23b. Did	tobacco use c	ontribute t	to the cause of death?	
P.O. that the de by the detached	The state of the state of							1 🗆	Yes 210 No	3 Pro	bably 4 Unknown	
dS, Flines the signed d be det												
The law requires th tate has been signed page 2 should be d	PERSONAL PROPERTY.							24a. Was	s an autopsy formed?	av	ere autopsy findings vailable prior to	
aw re					-					of	ompletion of cause death?	
I Re law The law ate hes page 2	2000							10	Yes 2 No	1	☐ Yes 2☐ No	
Vital I	25. Was case referred to medical		100000			26. Place	e of Death	(Check only	one)	1		
	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ent 2 ER/Outpa	tient 3 DO	A Oth	AP.			sidence 8 🗆 Of	ther (Speci	(fv)	
Phys rethis araldi	27. Manner of Death	28a. Date of Inju (Month, Da		of 28	Bc. Injui		-		how injury occu		,,,	
ding th.: After s fune	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		y Year) Injur	У		Yes 2	No					
Visio	3 ☐ Suicide 6 ☐ Could not	be 28e. Placa of Ini	ury - At home, farm.	street, factory.	office					nber or Rur	ral Route Number,	
Division of all or Attending P is a ther death.  It Director: After the din by the funers  Certification:	4 Homicide	building, ef	ury - At home, farm, c. (Specify)					City or To	own, State)			
Med and a second	29a. Certifier 1X Certifying P	hysician: To the best	of my knowledge de	ath occurred a	t the ti	me date ar	nd place a	and due to the	e cause(s) and n	nanner as f	hatata	
Divisor  To the Hospital or Affe within 24 hours after de To the Funerel Directo completely filled in by th  Medical Certific		miner: On the besis of	examination and/or									
Mec Mec	29b. Signature and little of certifier	and manner 50		29c	Licens	e number			29d. Date sign	ed (Month.	Day, Year)	
F.3 F.8		4 1						1				
15	Laule	ne_MD		D2	2275	5			Sept.	30, 20	000	
	30. Name and address of person who					1			707			
	Christine Delima,		Van Dusen	Road #	260	Lau	rel,	MD 20	707			
State	31. Date filed (Month, Day, Year)		ar's Signature	1		,						
Registrar	001 0 % 2	-000	1	do	El.							



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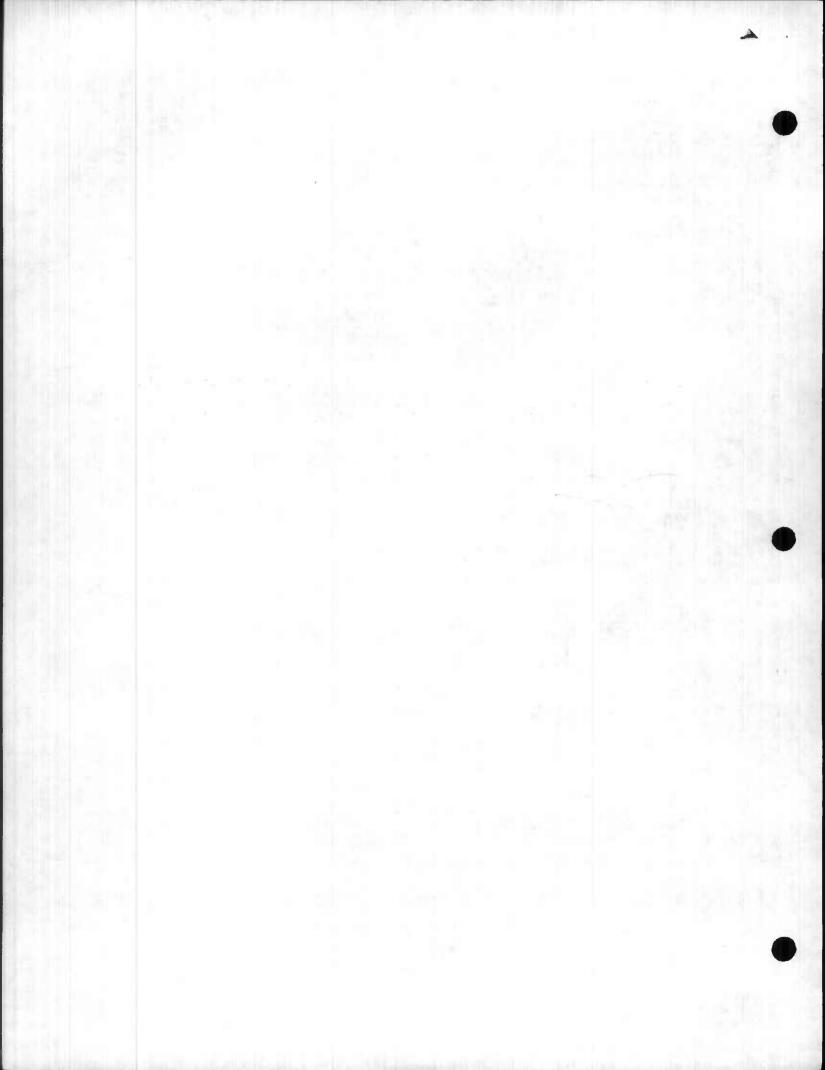
				Certifica	te of	Death		Reg	. No.						
	1. Decedent's Name (First, Middle,	Last)						of Death			3. Time	of Death			
Physician	ENGINEERING STREET	Clevie	L. Koh	1			Sept	n embe:	r 26, 2	000	7:0	5AM			
/Medical	4a Facility Nama (If not institution,					4b. City, Tow	n, or Location of		4c. County						
Examiner	Randolph Hills 1	Nursing Home		a a la la la la color	er 1 Yaar	Wheat		(8)	Montg						
Funeral Director	218-22-6622	3. Sex 7. Ag 1  M 2	e (In yrs. last bir	Yrs. Months		Hours	Min. Oct.	25,	1919	10d. Inside City Limits 1 □ Yes 2 No en of What Country? ted States 4. Race - American Indian, Black, White, etc.  Specify: White d of Business/Industry  Dwn Home  Sumame)  Town, Stete, Zip Code) Virginia 20120 cation - City or Town, State esda, Maryland ne/Bethesda-Chevy Chase, Inc.  Approximate Interval Between Onset and Death					
DG &	Usual Residence of Decedant  10a. State 10b. County		10c. City, Town	n or Location						1	0d. Inside	City Limits			
Marylar in-f ahow uted at	Maryland Montgo	omery		heaton											
3a or 28	10e. Street and Number 4011 Randolph I	Road		10f. 2	ip Code	902									
72 hours after death with the Maryland natural; or terms 23a or 28a-f ahow oral Examiner must be noticed at each by Funeral Director.	11. Marital Stafus  1 □ Never Married 2 □ Marrie  3 월 Widowed 4 □ Divorced	12. Was Decedent Armed Forcas?  d 1 Yas 2 12 1 If Yes, Give Year or Dates:				lispanic Origi an, Mexican, Specify:	in? (Specify Yes Puarto Rican, et	or No- c.)	Blac	ck, White,	etc.	,			
natural',	15. Decedent's		16a.	Decedent's Us	ual Occup	etion	of working	16	b. Kind of B	usiness/înc	Justry				
C	(Specify only highest Elementery/Secondery (0-12) 7	College (1-4or 5	5+) H	(Give kind of v life. DO NOT omemake		d) most	or working		Own	Home					
Hygir Hygir	17. Father's Name (First, Middle, L.	ist)				18. Mother	's Name (First, N	fiddle, Ma	14. Race - American Indian, Black, White, etc.  Specify: White  D. Kind of Business/Industry  Own Home  iden Sumame)  Tr  ify or Town, Stete, Zip Code)  1e, Virginia 20120  D. Location - City or Town, State  ethesda, Maryland  Home/Bethesda-Chevy Chase, Inc.  Approximate Interval Between						
antal H antal H out out	*******						Nellie H	Baxte	r						
should ind Menind Menin	19a. Informant's Name/Relationshi	(Type Print)	19h	Mailing Addre	es (Street	end Number	or Rural Route I	Vumber (	City or Town	State Zin	Code)				
d 2 s th an 7 is 1	Mary E. Egnor/Da							Rural Route Number, City or Town, Stete, Zip Code)  Centreville, Virginia 20120							
1 end Health In 27 Ither to	20a. Method of Disposition	ugiitei	20b. Place of	Disposition (N	ame of			-							
permit. Pages 1 end 2 should be filled within Department of Health and Mental Hygiena. Important: if item 27 its marked other than any injury or other traumatic avent, the Mence.	1 Burial 2 Cremetion 3 4 Donetlon 5 Other (Spe			nery Crem				200. Location - City or Town, State 2000 Bethesda, Maryland							
permit. Departr Importu any inju	21. Signature of Funeral Service Li	censee	M00198	7557	Wisco	onsin	Avenue			Bethe Cha	sda-	Chevy Inc.			
Physician	23a. Pert1. Enter the diseese, or c shock, or haart failure. List o	omplications that caused aly one cause on each li	fhe death. Do	not enter the m	oda of dyir	ng, such as c	ardiac or respira	1814-3501 ratory arrest, Approximate Interval Between							
/Medical Examiner	Immediate Causa (Final disease or condition resulting in death)	a. Septio	emia		D.				4-3501 arrest, Approximete Interval Between Onset and Death						
sit sit		Gangre		consequence o	1).						mont	hs			
an and inal-tran	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)  Cause (Disease or injury)										year	S			
death certificate be executed e attending physician and of or use as the burial-transit siclan/Medical Examiner	that initiated events resulting in death) Last														
atten for u							1								
that the death cer ted by the attendir detached for use y Physician/A	Part II. Other eignificant condition Atrial Filbrill	236		acco uae co 2 □ No			se of death' I⊠ Unknow								
The law requires that the death certicate has been signed by the attending page 2 should be detached for use a Completed by Physician/M	Multiple Decubi						24a	Wes an	eutopsy ed?	ev	ere eutop railable pri impletion	sy findings ior to of causa			
The law ate has the page 2 s								1 🗆 Yes	2 🖾 No	of	death?				
certificate rector, pag	25. Was case referred to medical					26. Place	of Death (Check	only one	}						
	examiner?	Hospital:	ant 2 ER/Ou	utpatient 3	OA OH	nor:	sing Home 5	-		nar (Specii	(v)				
2 2 2	27. Menner of Death	28a. Dete of fnju (Month, Da		Time of	28c. Inju Wo				injury occur		,,				
tal or Attending P rs after death. el Director: After t led in by the funers Certification:	1 Natural 5 Pending 2 Accident investige 3 Suicida 6 Could not determine	tion 28e. Place of Inj	ury - At home, fe	M erm, street, fact	1□	rk? IYes 2□N	28f. Loca	ation (Street and Number or Rurel Route Number, or Town, State)							
Hospi 24 hou Funer taly fil	29a. Certifier (Check only one)  29a. Certifier (Check only one)  1X Certifying Phyetcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner of the cause (s) and menner											se(s)			
within 2 To the compla	and manner stated.  29b. Signature end title of certifier  29c. Licansa number  29d. Date signed									d (Month,	Day, Yea	ir)			
F 3 F 8										tember 26, 2000					
	30. Name and address of person we Martin C. Sharge				renue	, Kens	sington,	Mary	yland	2089	)5				
State	31. Data filed (Month, Day, Year)	32. Registr	ar's Signeture	4	9										



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					Cei	tificat	e of	Death		Reg. No.		2011			
Dhusisian	1. Decedent's Name (First, A	liddle, Las	t)					THE RES	2. Date of De Month	Day	Yeer	3. Tima of Death			
Physician /Medical	EDWARD KLI	NGER							SEPT.		000	6:05 PM			
Examiner	4a Facility Name (If not instit			r)				4b. City, Town, or		· ·					
	257 CONGRESS						1	ROCKVII			GOMERY				
Funeral Director	5. Social Security Number 127–32–7235		x 7. A	nge (In yrs. la 94	est birthday) Yrs.	If Under Months	Days	Hours Min		ly, Year)	9. Birthpla Countr POLA	ace (State or Foreig ry) ND			
	Usual Residence of Deceder 10a. State 10b. Co			10c. City	. Town or Lo	cation	-				10	d. Inside City Limits			
with the Maryla a or 28s-f show be notified at Director		TGOME	DV	POC	CKVILL	r ·						1 Yes 2 □ No			
or 28s-1 s be notified	10e. Street and Number	TGOTTE	N.I.	KOC	VK A TITI	10f. Zip	Code			10g. Citizen of 1	What Countr	n/2			
0 20	257 CONGRESS	TONAT	LANE			101. 2.40	, 0000	20852	64-71	U.S.		,,,			
matth matth	11. Marital Status	TONAL	12. Wes Deceder	t Ever in U.S	S. 13. V	Was Dece	dent of I		Specify Yes or No		· A ·	n Indien.			
natural", or items 23 dical Examinar must sted by Funeral	1 Never Married 2 37 Widowed 4 Divo	174-	Armed Forces  1 Yes 2X  If Yes, Give  Year or Dates	? ] No		f Yes, spec		lispanic Origin? ( an, Mexican, Pue Specify:	rto Rican, etc.)	Specify Specify	ck, White, e	tc.			
ted bet		edent's Edi			16a. Deced	dent's Usua	al Occup	pation		16b. Kind of B					
ygiene, neturn 4, the Medical Completed	(Specify only h Elementary/Secondary (0-		de completed) College (1-4o	(54)	(Give	kind of wo DO NOT u	rk done se retire	during most of wo	orking						
The state of	12	,	Compage (1 40	34,	GR	OCER				SE	LF-EMI	PLOYED			
d othe event, Be C	17. Father's Name (First, Mic				111			18. Mother's Na	me (First, Middle	, Maiden Sumen	n <i>e)</i>				
To B	MEYER KLINGE	R						SABI	NA (UNOBT	AINABLE	)				
27 is ma ir treuma	19e. Informant's Name/Rele DR. HERBERT F														
ury or othe	20a. Method of Disposition			e CE	ace of Dispo	netory or o	other pla		Date 0-2-00						
事	4 Donation 5 Other (Specify) KIRYAT SHAUL CEMETERY 10-2-00 TEL-AV														
anny a	22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPEI 1170 ROCKVILLE PIKE, ROCKVILLE, MD 2 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haunt latters. List only one cause on each line.														
	23a. Part1. Enter the disease shock, or heart fallure.	e, or comp List only o	lications thet cause ne cause on eech	ed the death line.	. Do not ent	er the mod	le of dyi	ng, such es cardie	c or respiratory e	SELF-EMPLOYED  e, Maiden Surneme)  TAINABLE)  ber, City or Town, State, Zip Code)  OTOMAC, MD 20854  20c. Location - City or Town, State  TEL-AVIV, ISRAEL  AL CHAPEL, INC  ILLE, MD 20852					
sician ledical	Immediete Cause (Final		6	0	COIE										
miner	disease or condition resulting in death)		a. 0/	gna R							1	month			
<b>1</b> 5			D <sub>a</sub>	Due to (or	u Vas	quence of):	^	Dis ease		11.000					
hei-transit Examiner			b. Teru	_			1	un eure				1 year			
X Bi-tra	Sequentially list conditions, if any, leading to immediate			Due to (or	es e conseq	luence of):									
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	~	c								1				
odical	resulting in death) Last			Due to (or	as a conseq	uence of):									
ding p			d												
igned by the ettendin be deteched for use by Physician/N															
be detected for use by Physician/M	Pert II. Other significant con					nderlying c	ause gi	ven in Part I.	23b. Did	tobacco use co	entribute to	the cause of death			
de la	Anteriosclet	ofed	Heart	Dise	ase				10	Yes 2 No	3 Prob	ably 4 ☐ Unknow			
D P									24a Was	an eutopsy	24h Wei	re autopsy findings			
Completed	Anemia								perf	ormed?	avai	ilable prior to apletion of cause			
e 2 mpi			- 11 11 11								of d	eath?			
Se Co									10	Yes 2 No	10	Yes 2 No			
director, page 2 s	25. Wes case referred to me examiner?	-							eth (Check only	one)					
T.	1 Yes 213 No		Hospital: 1 Inpa	tient 2 🗆 l	ER/Outpatier		JA		Home 5 Res			)			
D Lier	27. Manner of Death 1 BNaturat 5 ☐ Pe	ndina	28a. Date of In (Month, D		28b. Time of Injury	2	28c. Inju Wo	ry at rk?	28d. Describe	how injury occur	berr				
he fu	2 Accident im	restigation				М	10	Yes 2 □ No							
al Director: Aftert led in by the funera Certification:	3 ☐ Suicide 6 ☐ Co	ould not be termined	28e. Place of Inbuilding,	njury - At hos	me, ferm, str	eet, factory	y, office		28f. Location ( City or To	(Street and Numi wn, Stete)	ber or Rurel	Route Number,			
To the Funeral Direction of Completely filled in the Medical Certification of Certification															
To the Funeral Director: Affer this certificate in completely filled in by the funeral director, page Medical Certification: To Be Com	(Check only 2 Med	ifying Phylical Exami	reician: To the bes iner: On the basis	t of my know of examineti	vledge, death	occurred vestigation	at the ti	me, date and place	e, end due to the	cause(s) and m	enner as sta	ated. the cause(s)			
Med	one)		and manner s	steted.											
	29b. Signature and fittle of ce	-1	5/1		0	290	C. Licen	se number		29d. Dete signe					
10	ter	D.	There	m	V		11:	2/9/0		October	/	000			
	30. Name and address of per	son who o	ompleted cause of	death (Item	23а) (Туре,		^		on, mo		,				
	Peter B. She	rer v	mv 39	21 9	errar	Q	Dr.	Wheat	on, mil	2090	6				
State	31. Date filed (Month, Day, Y		1	trar's Signat	ure	-									
Registrar	OCT O	6 20	00 4		KA	1	- 1								

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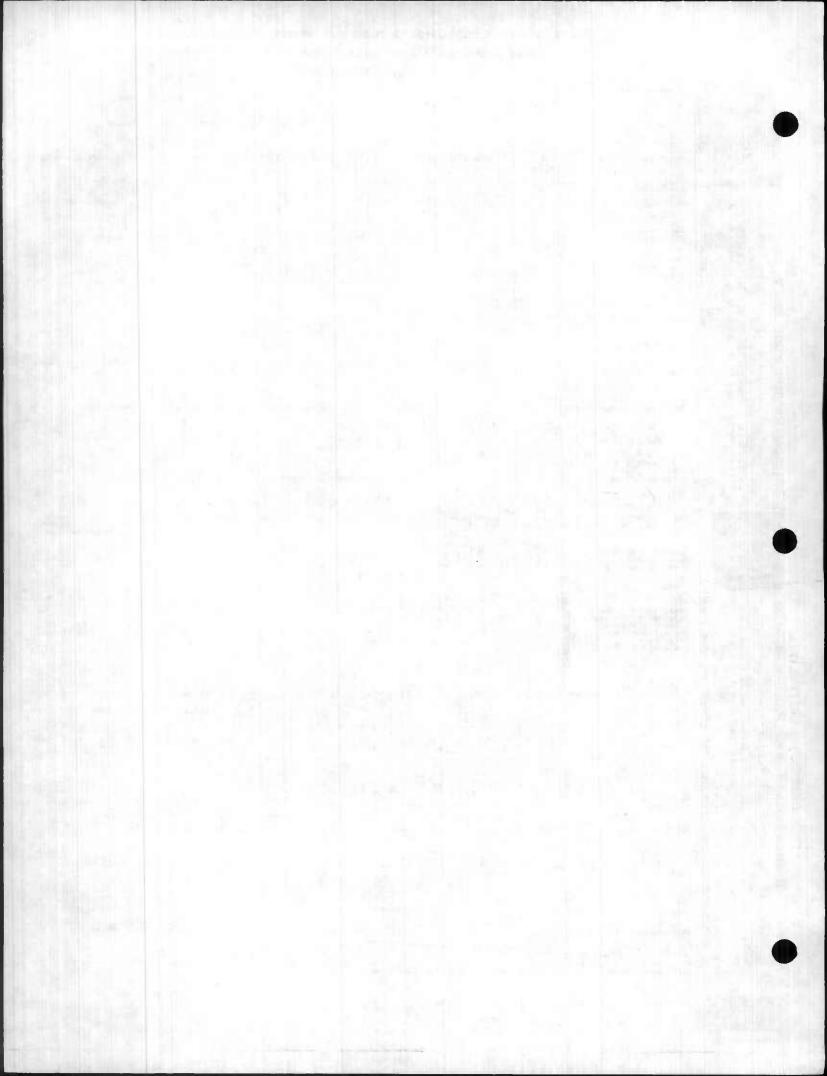
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Certificate of Death

				Certific	cate of	Death		Reg. No.			
Physician	1. Decedent's Name (First, Middle, L						2. Dete of De Month	Dev	Year	3. Time of Death	
/Medical		Theresa	Kelle	r		4b. City, Town, or	Octobe			8:30 AM	
Examiner	4e Facility Name (If not institution, g 1110 Grandin Ave					Rockvill			gome	ry	
Funeral Director	5. Social Security Number 175–20–6170 6.	Sex 7. A 1  M 2	ge (In yrs. last bir 74		Inder 1 Year onths Deys	If Under 24 Hrs Hours Min.		th Year) 1,1926	9. Birthp Coun Penn	lace (State or Foreign stry) 18y1vania	
2 .	Usual Residence of Decedent		400 City Town	n on t continu						Od Jasida Olba Limita	_
or 28a-f show he notified at Director	Md. 10b. County Montgon	nery	Rockv:		n					0d. Inside City Limits 1 ☐ Yes 2 No	
be notified	10e. Street and Number			10	of. Zip Code			10g. Citizen of V	Vhat Cour	itry?	
	1110 Grandin Ave	nue			20	0851		United	State	es	
inners 23 inners 23 inners 23	11. Merital Status	12. Was Decedent Armed Forces	?	13. Was I If Yes	Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	)- 14. Rac Blac	a - Americ k, White,	an Indian, etc.	
by by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X If Yes, Give Yeer or Dates:		1 🗆 Y	es 2∑ No	Specify:		Specify	Whi	te	
Scall Scall sted	15. Decedent's I		16a.	Decedent's	Usual Occup	ation during most of wo	rkina	16b. Kind of Bu	siness/Inc	dustry	
t, the Medical Completed	Elementary/Secondary (0-12)	College (1-4or				during most of wo		24-			
	12		HC	ostess	3	40 Mathada Na	- /Final Middle	Marriot		rp.	
fo Be	17. Father's Name (First, Middle, Las Peter Winovich	37)					ine Str		10)		
1	19a. Informant's Name/Relationship	(Type, Print)	19b	. Meiling Ad	dress (Street	and Number or R	urel Route Numb	er, City or Town,	wn, Stete, Zip Code)		
# II	Michael J. Kelle	r (Husband	/			Ave. Roc	kville,				
ry or oth	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec			y, cremetor	y or other pla	emetery	Oct. 5, 2000	20c. Location - Silver			
mporta any inju	21. Signature of Funeral Service Lice	ensee			me and Addre	. L	eVol Fu	neral Ho			
5.705	Cueles C-	Sea of				Park Dr			, MD	Approximate	
sician	23a. Part1. Enler the disease, or co shock, or heart failure. List onl	mplications that cause y one cause on each	ed the death. Do r line.	not enter the	e mode of dyll	ng, such as cardia	c or respiratory e	orrest,		Interval Between Onset and Death	
ledical aminer	Immediate Cause (Finet disease or condition	Ventri	cular Fi	brill.	ation					5 minutes	
	resulting in death)		Due to (or as a	consequenc	ca of):				-		
n lue		b. Conges	tive Hea	rt Fa	ilure			1	3 years		
as the bunal-trensit  O, M.D.  Redical Examiner	Sequentially list conditions, if eny, leading to immediate		Due to (or as a	consequenc	e of):						
M.I.	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	c. Dilate	d Cardio	-	-				i	3 years	
ko,	that initiated events resulting in death) Last	Atrial	Due to (or as a o						1	3 years	
nsk an/N		d	1101111						1	,	
o by the attending pletached for use as a Tomsko Physician/Me	Part It. Other eignificant conditions	contributing to death	but not resulting in	n the underly	ying cause gh	ven in Part I.	23b. Did	tobacco uae co	ntribute t	o the cause of death	?
igned by the attento be detached for uncida Toms by Physician	Gram Street	Diabet	es				10	Yee 201No	3 Pro	bebly 4 Unknow	m
been s should ttri		Hypert	ension				24a. Was	an autopsy ormed?	ev	ere autopsy findings allable prior to impletion of cause death?	
E SHE							1 🗆	Yes 2∏ No	1[	□Yes 2□ No	
B. E. Bertiffi	25. Was case referred to medicat examiner?	Hoenital.			100	oor:	ath (Check only				
m M.	1 Yes 2 No		ient 2 ER/Ou	rime of	LIDOA			idence 6 Oth		(y)	
etor: After the by the funeral ed by I	27. Manner of Death 1 Naturel 5 Pending 2 Accident investigati		28c. Inju Wo	ryat rk? ∣Yes 2 ☐ No	28d. Describe	how injury occur	Det				
To the Funeral Director: After completely filled in by the funeral A/Released by Medical Certification	3 ☐ Suicide 6 ☐ Could not determine	28e. Plece of Ir building, e	njury - At home, fe ntc. (Specify)	rm, street, f	actory, office			(Street end Numl wn, State)	er or Run	al Route Number,	
completely filled in ed/Releas Medical Cert	29a. Certifier 1 Certifying F (Check only one) 1 Medical Exi	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occu					e, end due to the urred at the time	cause(s) and ma date and place,	anner as s	itated. o the cause(s)	
ed/led/	29b. Signature and title of certifier		29c. License number				29d. Date signed (Month, Day, Year)				
are	1 am	_1			1	1415	20	October	3. 2	2000	
U .											
CI	Mark Milner, M.D.	, 6410 Ro	ckledge			hesda, M	D 2081	7			
State	31. Dete filed (Month, Day, Year)	32. Regist	trar's Signature	1.	1	,					

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State of Maryland / Department of Health and Mental Hygiene 328/9

						(	Certifica	ate of	Death		R	eg. No.		/ La O 1 J
200		1. Decedent's Name (First,	Middle, Last)	)			Service Control			2	. Date of Deat Month		Year	3. Time of Death
	Physician /Medical	JAI	N R	OBERT	KAU	JISKY			1.6.	5	EPT.	30, 200		10:30 AM
	Examiner	4a Facility Nama (II not ins	titution, giva	street and number	er)	1			4b. City, Town	, or Loca	tion of Death	4c. County	of Death	
		SUBURBAI	N HOSP	ITAL						ESDA	1	MON	TGOM	
	Funeral	5. Social Security Number	6. Set	x 7 0 M 2□ F	Age (In yrs.		Months	ar 1 Yaar s Days		Hrs. 8	Date of Birth (Month, Day,		9. Birthpl Coun	lace (State or Foraign try)
	Director	213-56-9052		201	51	Yı	S.			0	TUNE 15	, 1949	HAW	AII
	P	Usual Residence of Deceder 10a. State 10b. C			10c. Ci	tv. Town	or Location			_			10	Od. Insida City Limits
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	vith the Maryla t or 28a-f sho be notified at Director	MD. Mo	ONTGOM	ERI		5	ILVER 101.7	SPRI.	IVG		1	Og. Citizen of V	Vhat Coun	to/?
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-	ther death or there 23 diper must.	1 Nevar Marriad 2	20 20 10 1	Armed Force	s?		tf Yes, sp	ecify Cub	Hispanic Origin ban, Mexican, I	Puerto Ri	can, etc.)		k, White,	
050	di con al	3 ☐ Widowed 4 ☐ Div		If Yes, Giva Yaar or Date		-333	1 Yes	2₩ No	Specify:			Specify		HIVVE
21215-0020	2 ho seturn ted		cedent's Edu			16a. D	ecedent's Us	sual Occup	pation	4	(- 1977	16b. Kind of Bu		
215	ad within 72 ho inglens. we than "natural, the Medical. Completed	(Specify only : Elamentary/Secondary (0		e completea) Collega (1-4d	or 5+)	- 9	ife. DO NOT	use retire	during most o	r working				
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2 %	Ment Ment Ment Ment Ment Ment Ment Ment	ROBE	RT	KARL	KAU	JISKY	11			MAR	TORIE	STOI	TZ	
Maryland	2 sh and is m	19a. Informant's Name/Rai				19b. I	Mailing Addres	ss (Stree	t and Number	or Rural F	Route Number	, City or Town,	Stata, Zip	Code)
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3 10 altimore	2 = 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20a. Method of Disposition 1 ☐ Burial 2 Screma	ation 3 🗆 R	Removal from Sta			Disposition (Na cramatory or		ice)		Date	20c. Location -	City or To	wn, State
E E	Part of the Part o	4 □ Donation 5 □ Ott	her (Specify)			HAMB	ERS CR	TAMES	ORY	10	1/2/00	RIVER	DALE	, MD.
Sal	epart sport ny in	21. Signature of Funeral Se	ervice Licens	00	^		22. Name a	and Addre	ess of Facility					00006
2 m	20199	2/1/1/	han	nereisal	- MOC	091	CHAMB	ERS	FUNERAL	L HON	ES.P.A	., SILV	ER S	PRING. MD.
0	1015	23a. Part1. Enter the disea shock, or heart failure	ise, or compti	ications that caus	sed the deat	th. Do no								Approximata Intervat Between
w	Physician													Onset and Death
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D	n and si-transit Examiner			1	SCHI	EMI	A	OF	Bon	EL		70.7		
\$	and Hran	Sequentially list conditions if any, leading to immadiate cause. Enter Underlying			Due to (	or as a co	nsequence of	f):						
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68760	physici s the tu	that initiated events rasulting in death) Last			Dua to (d	or as a co	nsequenca of	f):						
	5 50 00			1										
Box	attends for use													
20	N 100 18	Part II. Other eignificant co	onditione con	ntributing to death	but not res	sulting in t	he underlying	g cause gi	iven in Part I.		23b. Did to	1.4	ntribute to	the cause of death?
70											1 🗆 Y	ea 21 No	3 Prot	bably 4 Unknown
Vital Records,	a sepa										24a. Was a	n autoney	24h We	ere autopsy tindings
0	ned mod										perfor		ava	ailable prior to mpletion of causa death?
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0 6	this o	1 Yes 2 No		1 D Inpa		ER/Outp		DUA	4LI Nuis			ence 6 Oth		0
	Ather lone		ending	28a. Data of I	Day Year)	28b. Tir Inj		28c. Inju	ork? ]Yas 2∐Ne		d. Describe n	ow injury occur	red	
To los	thend toor the	3 Suicide 6 □ C	nvestigation Could not be	00. Discost	lain Asse						f Location (C	troat and Mumb	or or Dum	I Route Number,
4 NO	ts after death.  Is after death.  Is Director: After to ed in by the funer.  Certification:	4 Homicida	determined	28e. Place of building,	etc. (Special		n, street, racto	ory, onica		20	City or Town	n, Stata)	er or nura	Addie Walliber,
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	n 24 hosp n 24 hos se Fune plotely fi	29a. Certifier 12 Ce (Check only 2 Me	dical Exami	ner: On the basis and manner	s of examina	owladga, o ation and/	or investigation	on, in my	opinion, death	occurred	at tha time, d	ause(s) and ma ate and place,	and due to	the cause(s)
	お足事と 46	29b. Signatura and titla of c	partifiar	and manner	Stated.		2	9c. Lican	isa number		2	9d. Date signe	d (Month.	Day Year)
-	5 10			M. D					36552					2000
	1			M.D.				2						
		30. Name and address of po	erson who co	omplated causa of W . Ed	mon (Iter	m 23a) (T	ype, Print)	+40	1 Pe	ch	ville	MD -	2080	52
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	State Registrar	31. Date filed (Month, Day,	3 200		erras	19	do	acks	1					

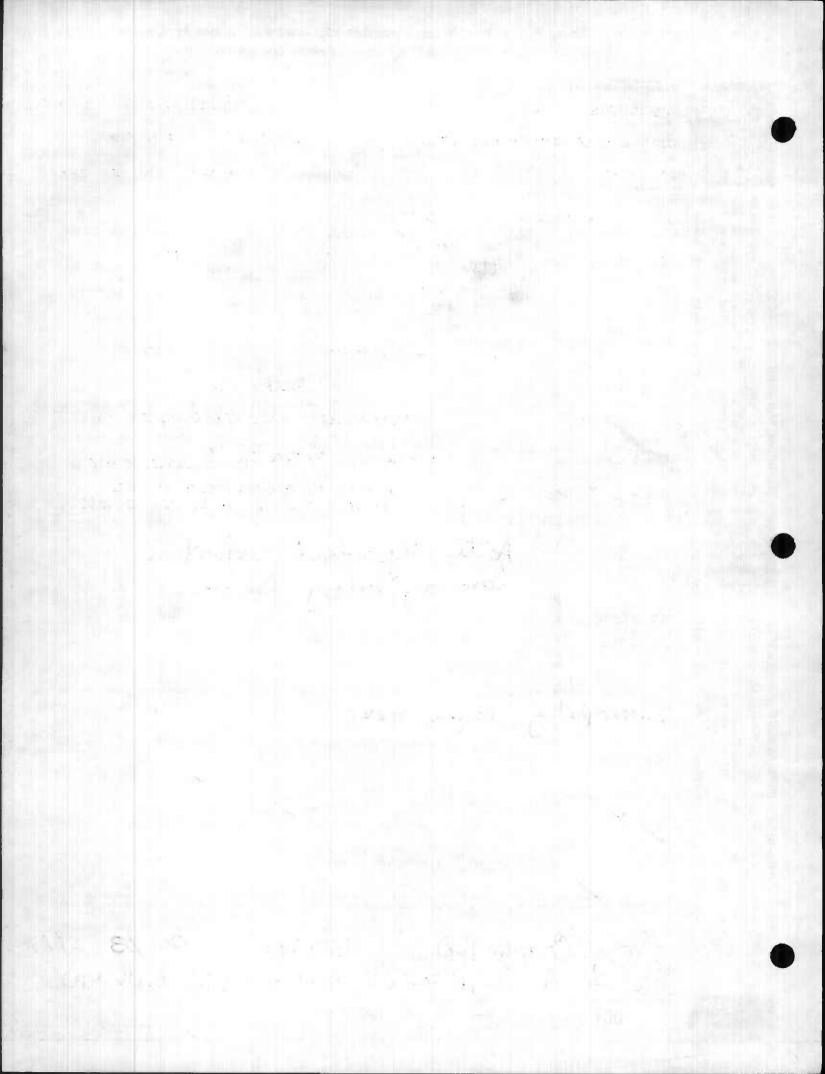
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middia, Last) 2. Data of Death 3. Time of Death **Physician** OCTOBER 3, 2000 3:00 AM DAVID KATZ /Medical 4e Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY HEBREW HOME OF GREATER WASHINGTON ROCKVILLE If Undar 24 Hrs. Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) If Undar 1 Year Birthplaca (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Days 1□M 2□F Months 82 Yrs NEW YORK Director MARCH 3, 1918 079-12-3436 Usuel Residance of Dacedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or heme 23s or 28s-f show any jolly or other traumatic event, the Modical Examiner must be notified at once. 10e. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1X Yas 2 No ROCKVILLE Director MONTGOMERY MD 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code USA 20852 Funeral 6121 MONTROSE ROAD 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-lt Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Raca - Amarican Indien, 11. Maritel Stetus 12. Was Decedant Evar in U,S. Armed Forcas? Black, Whita, atc. 1 Xas 2 No WWI.I 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 Specify: WHITE 1 Yas 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) BUILDING HOME BUILDER 4 18. Mother's Name (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) SADIE KANTOR LOUIS KATZ 19b. Mailing Addrass (Straat and Numbar or Rurel Route Number, City or Town, Stete, Zip Coda) 20815 19e. Intormant's Name/Ralationship (Typa, Print) 8101 CONNECTICUT AVE SOUTH 506, CHEVY CHASE, MIMI KATZ/WIFE 20b. Placa of Disposition (Nama of cematary, crematory or other placa) 20a. Mathod ot Disposition Data 20c. Location - City or Town, Stata Burlal 2 Cramation 3 Ramoval from Stata 4 Donation 5 Othar (Specify) OCT 4, JUDEAN MEMORIAL GARDESN 2000 OLNEY, MARYLAND 21. Signature of Funaral Service Licansaa 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. 20852 Approximata Interval Batween Onset end Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daeth) /Medical Examiner Examiner The law requires that the death certificate be executed physician and s the burial-trans Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaese or injury that initiated avants rasulting in daath) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consaquanca ot): attending pt 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yes 2 No 3 Probably 4 Unknown 205 W S should b 24a. Was an autopsy performed? 24b. Ware autopsy tindings available prior to Completed complation of cause of death? irector, page 2: 1 ☐ Yas 2 ☐ No Be 25. Was casa ratarred to medical 28. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Spacify) 10 1 Yas 2 No 3□ DOA After this 27. Mannel of Deeth To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th "completely filled in by the funeral 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury et Work? Certification: 5 Panding invastigation 1 Yas 2 No 2 Accidant 6 Could not be determined 3 Sulcida 28t. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, streat, tactory, office building, atc. (Spacify) 4 Homicida 16 cartifying Physicien: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and menner as stated. edical 29a. Cartifiar (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number (16 ausa ot death (Item 23a) (Type, Print) 30. Nama and address of person who Montrose Rd Rockville MD (MEGORY 31. Data tilad (Month, Day, Yaar) 32. Registrer's Signatura State OCT 0 4 2000 Registrar



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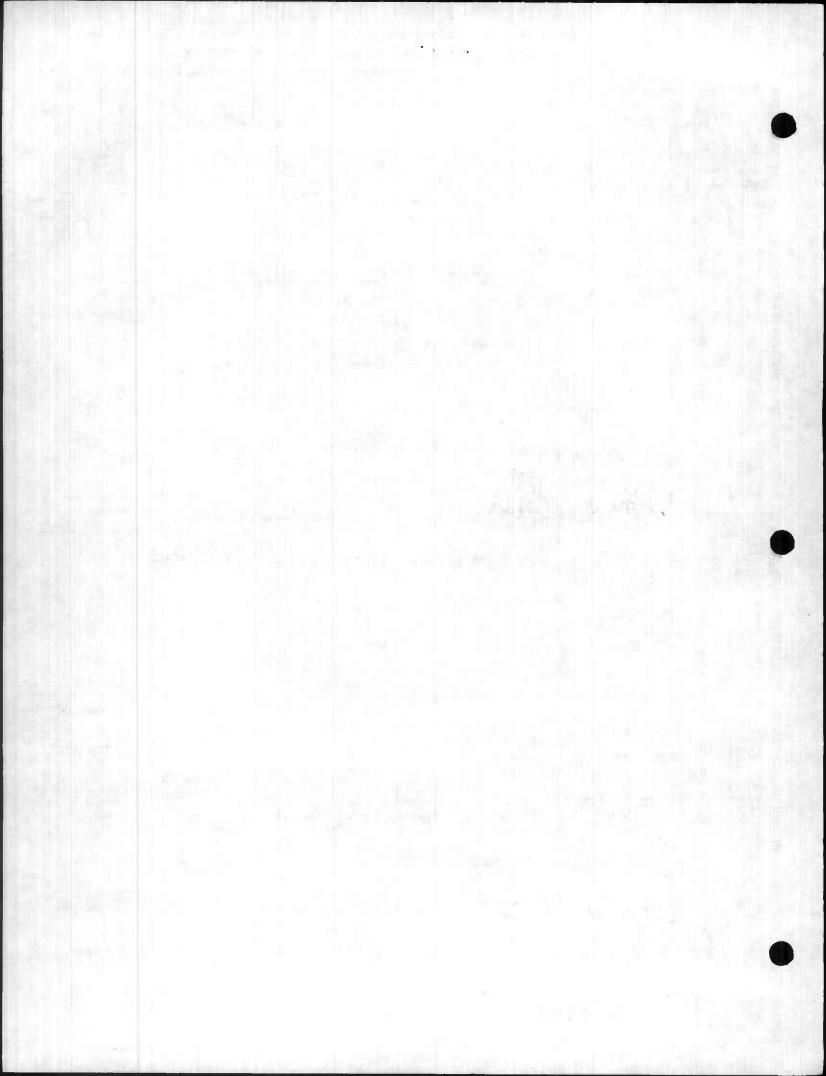
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** 0048 DAVID LAUR 00 /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 5. Social Security Number 219-26-3515 7. Age (In yrs. last birthdey) If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Min 10 M 20 F Months Days Hours 62 MD. Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Yes 2□No MD. WORCESTER OCEAN PINES Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 HERON ISLE CT. 21811 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Meritel Status 1 Yes 250 No If Yes, Give Year or Dates: 1 Never Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or it may Injury or other traumatic event, trailed to Barrand DAEs. 19-26-3575
Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WHITE Specify. p 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MERCHANT RETAIL 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) GLENDORA STEINBERG Louis LAUR 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 15 HERON CT. JOANNE LAUR OCEAN PINES, MD. 21811 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 Burlel 2 Cremetion 3 Removel from State
4 Donetion 5 Other (Specify) 9-30 SALISBURY, SALISBURY CREMATORY 21. Signeture of Furnerel Service Licens 22. Name end Address of Fecility ULLRICH FUNERAL HOME BERLIN, Mp. 21811 Wh 23e. Pent Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in deeth) ATHEROSCIERATTIC CARDIOVASCULAR DISEASE /Medical Examiner Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest Due to (or es a consequence of): and attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as e consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown á p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed hes 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifice Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 Medical Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier Jahren Wicholas L 34593 MD. 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) PINE BLUFFRE FUITEZE SALIBURY, mg 20801 OGBURN NICHULH MU 201 31. Dete filed (Month, Dey, Year) OCT 02 32. Registrer's Signeture State 2000

DHMH 16 Rev 6/95



## Please Type or Print in Biack indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month VICKIB LIVELY 0930 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 19012 HIGHBING ONIVE mediano CAPTHONS BUNG If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1□M 2♥F 52 Yrs. July 30, 1948 West Virginia 225-70-3352 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Montgomery Gaithersburg 10e. Street and Number 10g. Citlzen of What Country? 10f. Zip Code 19012 High Point Drive 20879 United States 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Virgil Garland Beavers Theada Stewart 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 20879 19a. fnformant's Name/Relationship (Type, Print) 19012 High Point Drive, Gaithersburg, Maryland Mark B. Lively/Husband 20b Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition October 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 3, 2000 Bethesda, Maryland 21. Signature of Pureral Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 23a. Part. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Approximete fnterval Between Onset and Death APARRIOSCLANATIC CHARDIDADYCULAR DUBBY Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of) Due to (or es e consequence of): Due to (or as a consequence of):

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be nant of Health and Mental int: If Hem 27 is marked o

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Directo

Funeral

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Completed

Be

physician and s the bunal-frans 38 use detached page 2 s has certificate this funerai After after death.

death certificate be executed

Division of Vital Records, P.O. Box 68760,

Attending

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24 hours after dea e Funeral Director pletely filled in by th

To the Hosp within 24 hor To the Fune completely fi

10

Examiner Physician/Medical P Completed Be To Certification:

29a, Contille

edical

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest

Part II. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Part I. MINCHOURM

23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were eutopsy findings available prior to 24a. Wes en autopsy performed? completion of cause of death?

Octo8821, 2000

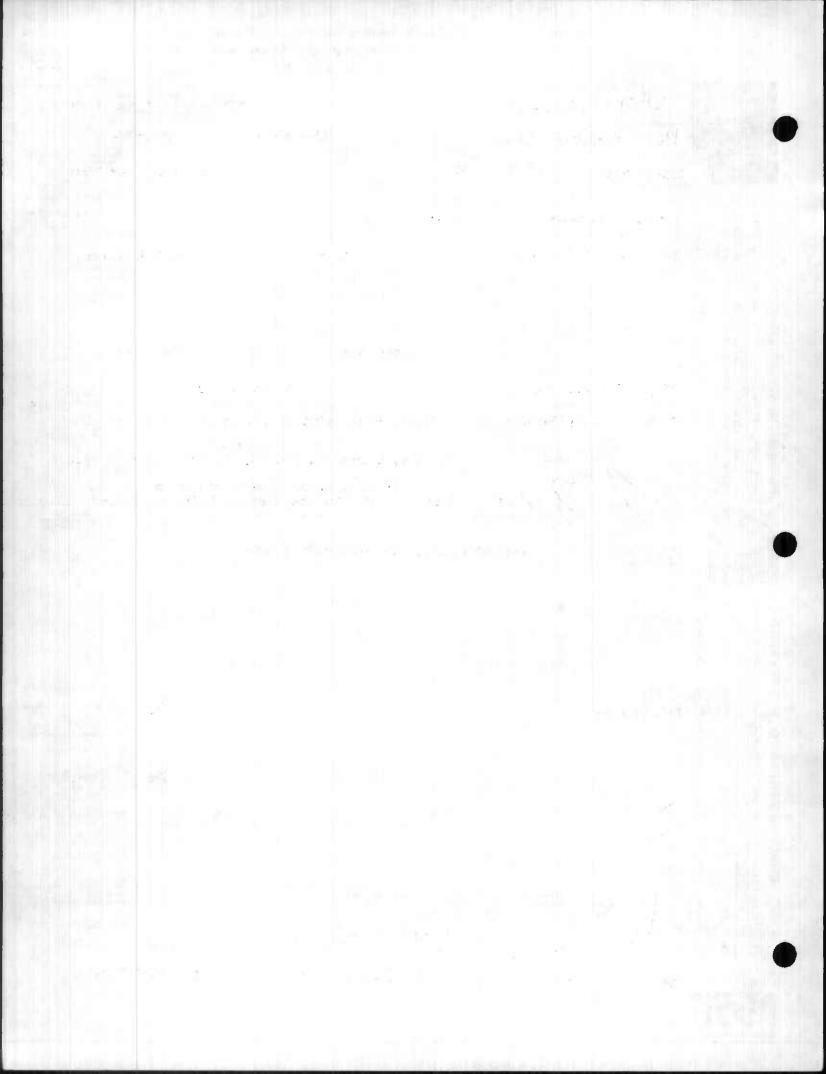
25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28h Time of 28c. Injury at Work? 5 Pending Investigation 1 Natural 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number 29d. Date signed (Month, Dey, Year) and title of certifier 015236

30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)
CALL I. WARGOLD, MD. (OME) (NOT) FOCKVILLE (NEE), GECKVILLE, MO 70852 (OMF)

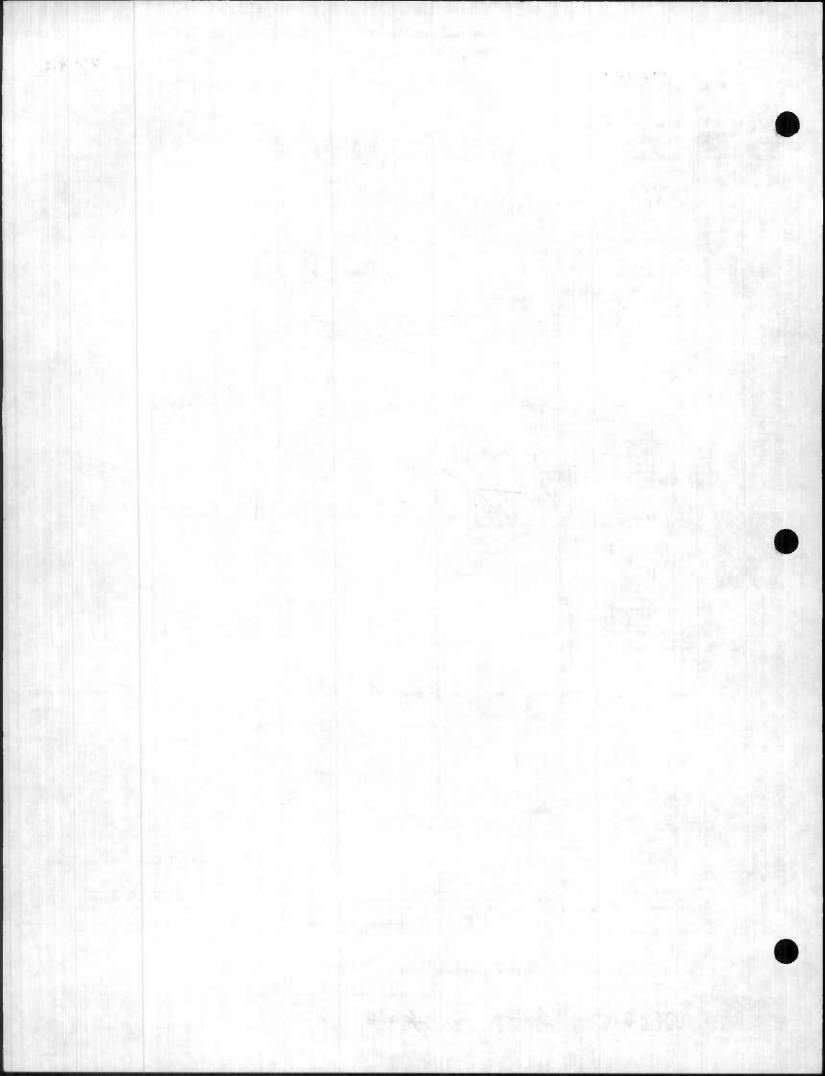
State Registrar 31. Dete filed (Month, Day, Year) 2000 32. Registrar's Signature



State Registrar 31. Data filed (Month, Day, Year)

Stephen Radentz, M.D. 32. Registrer's Signeture

111 Penn Street, Baltimore, Maryland 21201 ours



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 9:00 pm 2000 Lidji October 3, Elaine M. /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4215 Isbell Street Wheaton Montgomery If Under 1 Yeer 8. Dete of Birth (Month, Day, Year) Apr 6, 1936 If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Days Hours 1 □ M 2 🛛 F South Carolina Months 64 Yrs. 248-54-3335 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show o filed within 72 hours after death with the Maryta at Hygleds. other than "natural", or flering 23s or 28s-f show west, the Medical Examiner must be notified at t ☐ Yes 2 No Directo Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g, Citizen of Whet Country? 4215 Isbell Street 20906 USA Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 12. Was Decedent Ever in U.S. 11. Meritai Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Detes: Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) 12 should be fill and Mental H Be Isaac Marlowe Cora Thomas 19e, Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1.
Department of Health ar Important: If then 27 is Interpreted to other to Pages 1 and 2 s ment of Health an 4215 Isbell Street, Wheaton, MD 20906 John Lidji / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 10/5 N Burial 2 Cremation 3 Removal from State George Washington Cemetery 2000 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home, Inc. sence 500 University Blvd., W, Silver Spring, MD20901 Pent anter the disease, or complications that caused be death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical Cardiopulmonary Failure Acute Examiner Due to (or es a consequence of): Examiner Lung Cancer Chronic ed by the attending physician and detached for use as the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, beeding to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): Physician/Medical thet initiated events resulting in death) Last Due to (or es a consequence of): 97 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. been signed by should be detact 1 XYes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy tindings aveilable prior to comptetion of cause of death? page 2 should Completed 24a. Wes an autopsy performed? After this certificate has 1 Yes 2 No 1 ☐ Yes 2 No dal or Atte...
Aus after death.
Aeral Director: After this cen...
- in by the funeral director, pr of Vital 25. Was cese referred to medicat examiner? Be 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Lo 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Menner of Death 28c. Injury at Work? Certification: Division 1 X Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours of To the Funeral L Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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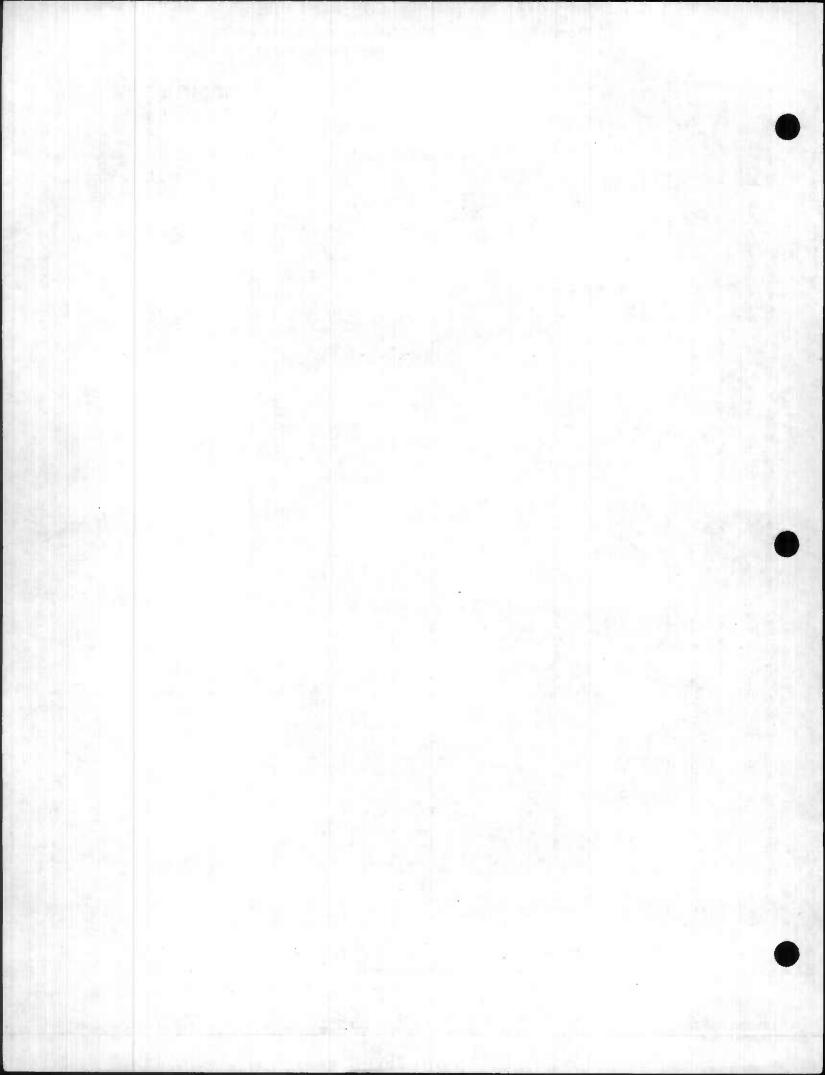
30. Nama end address of person who completed cause of death (Item 23a) (Type, Print)

John Walmark, MD 9707 Medical Center Drive #300, Rockville, MD

State Registrar MALLISAC

D 53177

October 4, 2000



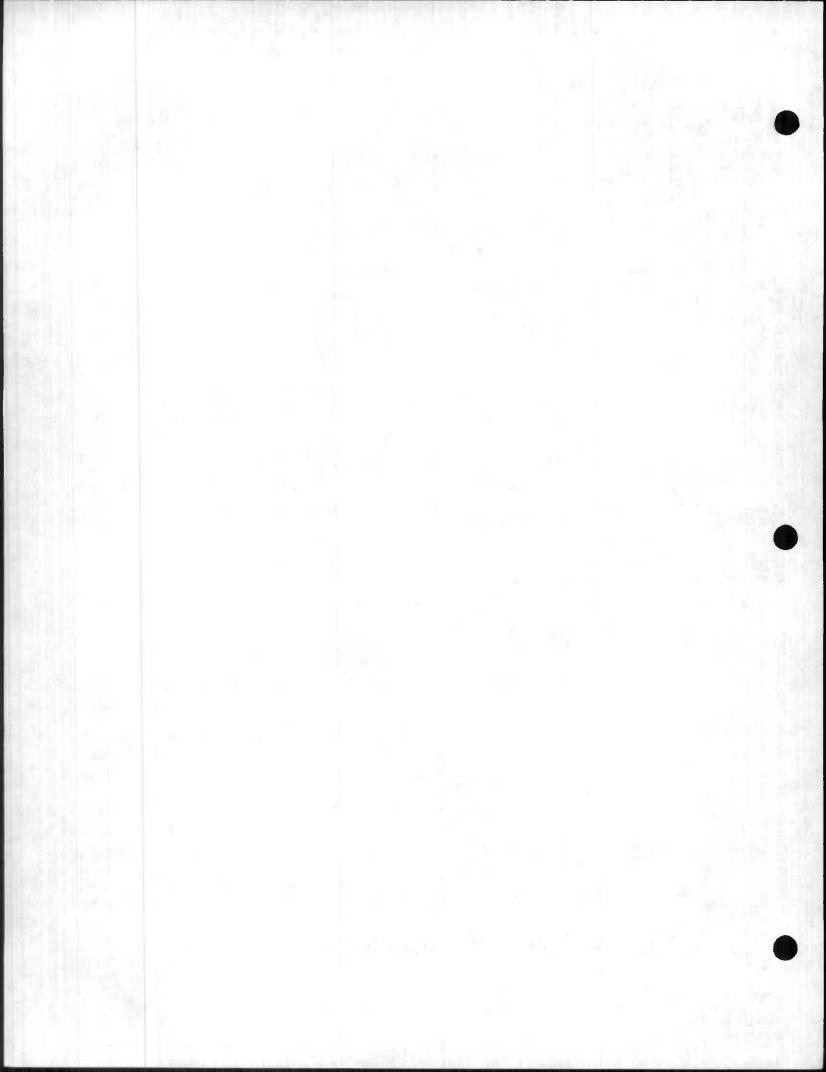
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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32825

						Ceri	illicate U	Deall	1		Reg. No.		
	Physician /Medical	1. Decedent's Name Barb	(First, Middle, La ara Ann							2. Date of De Month Septem	ber 26,	Year 2000	3. Time of Death 5:00 AM
	Examiner	4a Facility Name (If	not Institution, giv	e street and numbe	ir)			4b. City, 1	own, or L	ocation of Deat	h 4c. Count	y of Death	
		4717 Flo	wer Vall	ley Drive				Roc	kvil:	le	Mon	gome	rv
	Funeral Director	5. Social Sacurity Nu 270-26-808	mber 6. S		Age (In yrs. last	birthdey)Yrs.	if Under 1 Yas Months Day		Min.	8. Date of Bir (Month, De Jan. 9,	th		place (State or Foreign
	9	Usual Residence of D											
	how	10e. Stata	10b. County		10c. City, T	own or Loc	ation						10d, fnside City Limits
2	N T O	Maryland	Montgom	ery	Roo	ckvil	Le						1 ☐ Yes 2X No
	or 28s-f se nouffed	10e. Street and Num	ber				10f. Zip Code				10g. Citizen of	What Cou	ntry?
	N C C C C C C C C C C C C C C C C C C C	4717 Flow	er Valle	ey Drive				20853		4	United	Stat	es
1	death	11. Marital Status		12. Was Deceder	nt Evar in U,S.	13. W	as Decedent o	f Hispanic C	rigin? (S	pecify Yes or No o Rican, afc.)	- 14. Ra		can Indian,
0	r items 23 other must other must Funeral	1 Never Marrie	d 2X Married	Armed Forca	§? ΩNo	19.71				o Hican, atc.)		ack, White	, atc.
050	by by	3 ☐ Widowed 4	Divorced	If Yes, Give Year or Dates	s:	1	□ Yas 2X N	o Specii	y:		Spec	y. 1	White
ō	ed within 72 hours efter death with the Maryland ygiene. Water all, or Neme 23e or 28e-f show it, the Medical Examiner must be notified a Completed by Funeral Director		15. Decedent's E		1	6a. Deced	ent's Usual Occ	upation			16b. Kind of I	Business/Ir	ndustry
15	c 1 8 -		y only highest gra		-5.)	(Give k	ind of work dor O NOT use ret	ne during mi ired)	ost of wor	king			
212	filed within Hygiena.  Hygiena.  ther then and, the Me	Elementary/Second	dary (0-12)	College (1-4o	)r 5+)		Secreta	ry			High	Scho	ol
D	EITE M	17. Fathar's Name (F	irst, Middle, Last	)				18. Mot	her's Nan	ne (First, Middle	, Meiden Suma	me)	
an	id be fill the fill t	Adam Wech	r				Gladys Kindler						
7	d Men Tranke	19a. Informant's Nan		Time Print)		19b. Mailing Address (Street and Number or Rural Route Number, City o						n State 7	in Code)
-Baltimore, Maryland 21215-0020 permit. Pages 1 end 2 should be filed within 72 hours elt Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or what hylury or other traumetic event, the Medical Examples.  To Be Completed by F			•										
	E = 01 -	Leonard R. Leonard, Jr./Husband 4717 Flower Valley Dr. 20a, Method of Disposition 20b. Place of Disposition (Name of									20c. Location		
o		1 Burial 2 X Cramation 3 Removal from State cematery, crematory or other place)									20c. Location	- City or 1	Own, State
E	Pag ury c	4 □ Donation 5			Montg		Cremator:		C.	September 28, 2000			laryland
at	Parti.	21. Signature of Fun	egal Service Lices	олее									neral Home/
	285		1+ 4		MO1126	Ro	ckville	, Inc	30	0 West M 1 20850-	ontgome	ry Av	enue,
6		23a. Part1. Enter the	disease or com	inlications that caus	ed the death							- 1	Approximate
		shock, or heart	failure. List only	one cause on each	line.	DO HOL OHIO	The mode of c	,,,,,,					Interval Between Onset and Death
	Physician		i1										
	/Medical Examiner	Immediate Cause (F disease or condition resulting in death)		Stage	IV Endo	metri	al Canc	er	0.35			1.	l Year, 11Months
		1030iting in doatin)			Due to (or as	s a consequ	sence of):					1	
	aracuted in end ial-trensit Examiner			h								ì	
	certificate be assected nding physician end use as the burial-trensit n/Medical Examir	Sequentially list con-	ditions,		Due to (or as	s a consequ	ence of):						
68760,	urial urial	Sequentially list con- if any, leading to im- cause. Enter Underl Cause (Disease or in that initiated events	ying										
376	ysic he b	that initiated events resulting in death) La	est	C	Dua to (or as	a consequ	ence of):					i	
9	certificate be nding physicis use as the bu n/Medical	Tooding in dodiny as										1	
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00	requires that the death seen signed by the atter hould be detached for re	Part II. Other signific	ant conditions o	contributing to death	but not resultin	ng in the un	derfying cause	given in Pa	11	23b. Did	tobacco uss o	ontributs	to the cause of death?
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ō	been s should leted										ormed?	C	vallable prior to ompletion of cause
ec .	2 S S											0	f death?
E .	The la									10	Yes 2 No	1	☐ Yas 2☐ No
ita :	certificata rector, pag	25. Was case referre	d to medicai					26. Pla	ce of Dea	ath (Check only	one)		
>		examiner? 1 ☐ Yes 2 ☒ N	lo	Hospital:	atient 2 ER	VOutpatient	3□ DOA	Other: 4	Nursing H	lome 5 🕅 Res	idence 6 🗆 O	ther (Spec	eify)
o o	oral d	27. Manner of Death		28a. Date of Ir (Month, I	njury 28	b. Time of	28c. Ir	jury at		28d. Describe	how injury occ	urred	
0	the fundament	1 Natural 2 Accident	5 Pending investigation		Jay Year)	fnjury		Yes 2	□No				
Division	to a strending Price of a strending Price of the strength of t	3 Suicida	6 Could not be	289. Place of	Injury - Al home	e, farm, stre	et, factory, offic	00		28f. Location	(Street and Nur	nber or Ru	rel Route Number,
3	in bert	4  Homicide	dotominiou	building,	etc. (Specify)					City or To	iwn, State)		
	Hospital 24 hours Funeral Mely filled	29a. Cartifier	M Cartifying Di	nysician: To the be	et of mu broude	dae death	occurred at the	time date	and place	and due to the	neuse/s) and i	nannar ac	etated
	n 24 hound no 24 h			miner: On the basis	of examination								
	To the Hospital or I within 24 hours after To the Funeral Dire Completely filled in the Medical Certi		tion of contitional	and manner	SIBTOO.		99c Lin	ense numbe	IF.		29d. Date sign	ned /Mon**	Day Veerl
	0 × 0 0	29b. Signature and fi	tia or certified	11.	1.	1.	MA CO						
	15	D37236 September 26, 2000											26, 2000
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
		Carolyn B	. Hendri	icks, M.D	. 6410	Rock	ledge D	rive,	Betl	nesda, N	Maryland	1 208	17
	State	31. Date filed (Month		32. Regi	strar's Signatur	0 6	1	1.					
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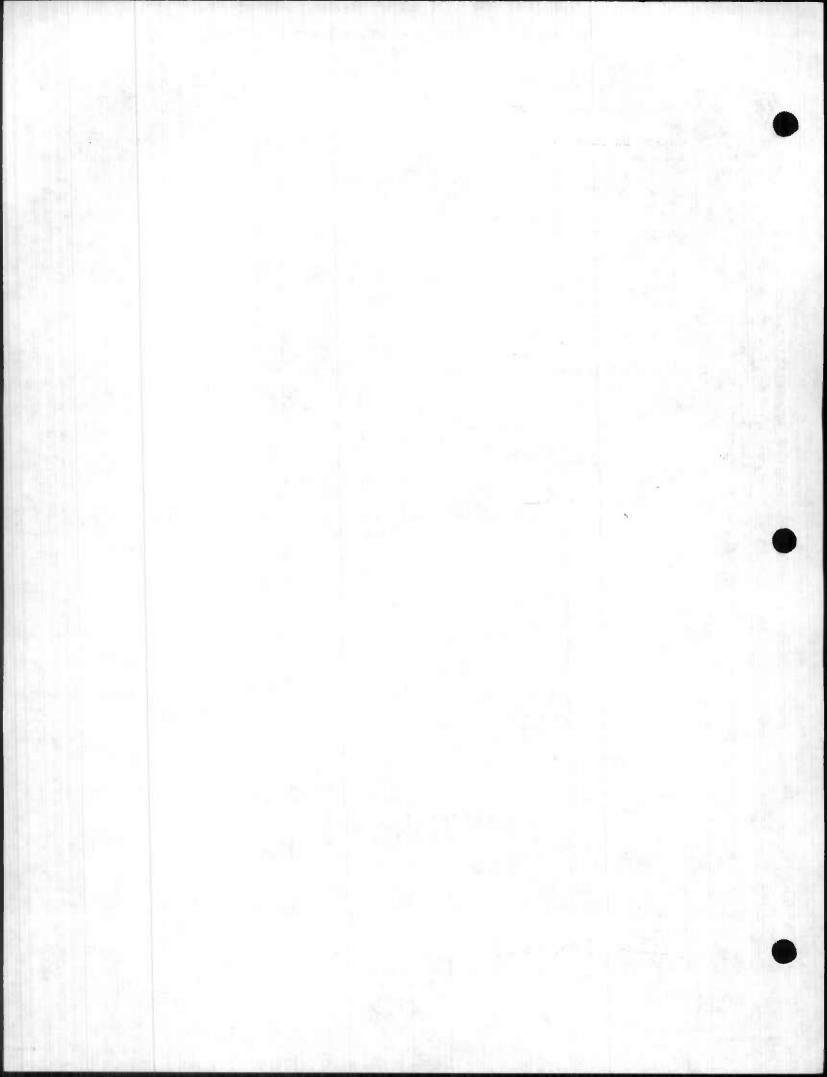
State of Maryland / Department of Health and Mental Hygiene

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32826

						Ce	rtifica	te of	Death			Reg. No.	00	06	020
		1. Decedent's	Name (First, Middle, Li	est)	1,- 01						2. Data of De	eath Day	Year	3. Time	of Death
	hysician /Medical	Edward	Benedict	Landr	у					14,74	Octobe			8:	15 AM
	xaminer	4a Facility Na	me (If not institution, gi	va street and nur	nber)				4b. City, To	own, or Lo	cation of Deat	h 4c. Co	ounty of Dear	th	
		Maplew	ood Park P	lace					Beth	iesda		M	iontgo	mery	
	neral ector	5. Social Secur 365-01	-4403	Sex 1∭ M 2☐ F	7. Age (fn yr: 94	s. last birthday) Yrs.	If Unde Months	r 1 Year Days	If Undar Hours	Min.	8. Date of Bi (Month, Di July 12	th ay, Year) 2, 190	9. Bird Co Mas	thplaca (State ountry) ssachus	e or Foreign setts
pug :		10a. State	10b. County		10c. C	City, Town or Lo	ocation							10d. Inside	City Limits
e Menyl	Director	Maryla	nd Montgo	nery	F	Bethesd	T							1 🗆 Y	es 21 No
ath with t	ral Dir	9707 O	1d Georget	own Road				2081				Unit	ed St	ates	
5-0020 72 hours after death with the Menyland	Evanive must be notified at	3 ⊠ Widow	tus  Married 2 Married  ved 4 Divorced	12. Wes Dece Armed Fo 1 Ves If Yes, Giv Year or De	rces? 2 X No		If Yas, spe	ecify Cub	Hispanic Or ean, Mexica Specify:	n, Puerto	ecify Yes or No Rican, etc.)		Black, Whit	erican Indian, le, etc. hite	
_ c .	Completed by	Elementery/	15. Decedent's E Specify only highest gr Secondary (0-12)		-4or 5+)	16a. Dece (Give life.	dent's Usi kind of w DO NOT	ork done	during mos	st of worki	in <i>g</i>	16b. Kind	of Business	Andustry	
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o ŝî	5 0		ama (First, Middle, Las	1)					18. Moth	er's Name	(First, Middle	, Maiden Su	imame)		
ylan buld be Mentel	To	Delph	is A. Land:	ry					Emi	lly A	nna Be	aubien	1		
2 should and Men			t's Name/Relationship	(Type, Print)		19b. Maili	ng Addres	s (Stree	t and Numb	er or Rura	al Route Numb	er, City or T	own, State,	Zip Code)	
	2	Joanne	L. Robins	on/Daugh	ter	8301	Rive	r Fa	alls D	rive	, Poto	mac, M	lary1a	nd 208	54
Saltimore, semit. Pages 1 ar	Co comper		f Disposition  2   Cremation 3 [ tion 5  Other (Speci		State	Place of Disponentery, cred	matory or	other ple	,		ct. 6,			Town, State	usetts
permit. Pages 1	any info	21. Signatur	of Funeral Service Lice	insee	MOC	198 R	obert	isco	Pumph nsin	irey Aven	Funeralue 20814	1 Home	/Beth	esda-C hase,	hevy Inc.
Phys	ioian	23a. Part1. Er shock, or	nter the diseese, or con r heart failure. List only	nplications that c	aused the de ech line.	ath. Do not en	ter the mo	da, de of dyi	Mary I ing, such as	and cardiac	or respiratory	=3501 arrest,		Approximete Interval Betwean Onset and Death	
	dical niner	Immediate Ca disease or cor resulting in de	ndition	a. Cere		cular A			leros	sis				20 y	ears
E 8	use as the buriel-transit	resulting in de		b		(or as a consec								7 7 7	
Seath cert	\$ \$ \$	Part II Other e	Ignificant conditions	contributing to de	eth but not re	sulting in the u	ınderlyina	causa di	ven in Pert	1	23h Did	tobacco us	se contribut	s to the caus	e of death?
T hat the	datached for use			contributing to de	atti out not re	Southing in the c	moonlying	ouddo gi	VOIT HIT OIL					Probably 4	
VICE The law requires the confidence of the conf	page 2 should be datached completed by Physic											s an autopsy ormed?	24b.	Were autopos available pri complation of of death?	or to
The lay	Page										10	Yes 2	No	1 Yes 2	2□ No
VILAI icien: Th	ractor, p	25. Was case	referred to medical						26. Plac	e of Deat	h (Check only	one)			
Physicien:	To B	examiner?	22 No	Hospital:	npatient 2	☐ ER/Outpatie	nt 3[] [	OA Ot	hor:		ma 5□Res		Other (Spe	ecify)	
ling A										1	28d. Describe				Me
DIVISION Aftender a ster death	£ 6	3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, farm, streat, factory, office building, atc. (Specify)									28f. Location City or To	(Street and a swn, State)	Number or F	Ru <i>ral R</i> oute N	lumber,
e Hospital	lical	29a. Certifier (Check on one)	1⊠ Certifying P 2 Medical Exa	miner: On the ba											e(s)
To the within 2	Me	29c. License										29d. Date	signed (Mon	nth, Day, Year	r)
	. /	T	A AM	AM				D42	423		1	Octob	per 2,	2999	
	25		address of person who		e of death (Ite	em 23a) (Type, Wiscon	Print)	Aven	ue #12	208,	Chevy	Chase	, Mary	land 2	20815
	State egistrar		(Month, Day, Year)		egistrar's Sig		-	als				- 1	LL I		

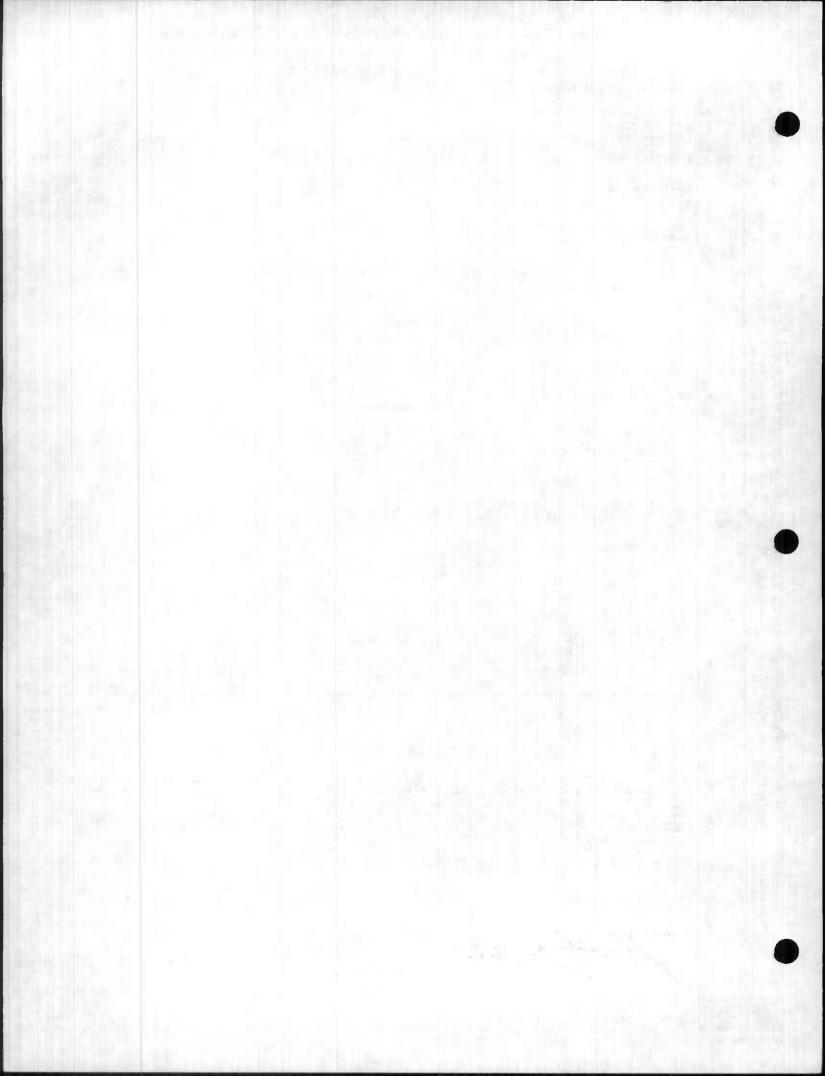
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 00 32827

					-	ificate o	Douth			eg. No.				
	1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Day										Yeer	3. Time	ot Deeth	
sician edical	JAMES H. LAKEM	AN, JR.	•			1 -64			OCTOBER	4, 200	00	9:52	am	
miner	4a Facility Name (If not instituti	200					4b. City, To	own, or Loc	ation of Death	4c. County	of Death			
	SHADY GRO	VE AD	VENTIS	T HOSI	PITA				VILLE		NTGO	MERY		
	5. Social Security Number	6. Sex	7. Age	(In yrs. last bir		If Under 1 Yes		Min.	8. Date of Birth (Month, Dey		9. Birthp	lece (State	e or Foreig	
	214-48-8817	IMI TAM	201	54	Yrs.				Apr 5,	1946	Mary	land		
	Usual Residence of Decedent  10a. State 10b. Count	h		10c. City. Tow	m or Loca	ation					1	Od Incide	City Limits	
*	Tod. State	y		100. 00, 100	II OI LOO	ation					0/2		s 2 No	
Directo	Maryland Montg	omery		01ney									- 21	
ă	10e. Street and Number					10f. Zip Code			1	0g. Citizen of V	Vhat Coun	itry?		
Funeral	3616 Sundown F					20830				USA				
	11. Meritel Status		Ves Decedent E rmed Forces?	ver in U,S.	13. W	es Decedent o Yes, specify C	f Hispanic Ori Jban, Mexicar	igin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)		e - Americ k, White,			
	1 Never Married 2 Ma	If	Yes, Give	0	10	□Yes 2□X	o Specify:			Specify	: Wh	ite		
	3 Widowed 4 Divorce		ear or Dates:											
	15. Decede (Specify only high	ent's Education lest grade com		16a	. Decede	int's Usual Occ ind of work dor O NOT use ret	upetion le during mos	st of workir	g	16b. Kind of Bu	usiness/Inc	dustry		
	Elementery/Secondery (0-12)	C	college (1-4or 5+	+)								TT		
	17 Esthar's blams (First bliefd)	- / cot)	1	M	leaic	al Cla				Teamst		unior	L	
	17. Father's Name (First, Middle	e, Last)					18. MOTH	er s Manie	(riist, Middle,	Walden Sumen	10)			
	James H. Lakem							yn St						
	19e. Intorment's Name/Reletion	nship (Type, P	Print)							r, City or Town,		Code)		
	Irene M. Lakem	an / W:	ife				n Farms	s Way	-	, MD 20				
	20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 DRamov	val from State	20b. Place o cemete	ry, creme	ition (Neme of etory or other p	lece)		Date	20c. Location -	City or To	own, State		
	4 Donation 5 Other		variioni State	Gate	of H	leaven	Cemete:	ry 10	/9/00	Silver	Spri	ng, N	ID (I	
8	21. Signeture of Funeral Service	e Licensee	0.		22.	Name and Add	ress of Fecili	ity	E 1	Ilama	Tena			
	1 / / / / / / /	Dim	( nle							Home,		100	0000	
	23a. Pert1. Enter the diseese, shock, or heart tailure. Li	or complice io	ns that caused i	the death. Do	not enter	the mode of c	ersity wing, such as	BIVd cerdiac o	respiratory err	lver Sp	ring	Approxim	nate	
	shock, or heart tailure. Li	st only one ta	use on each line	θ.							- 1	Onset an	d Deeth	
	Immediate Cause (Final		and the								1			
	disease or condition resulting in death)	a1	-								1	minut	es	
				Jue to (or es a	a. Myocardial Infarction  Due to (or es a consequence ot):									
٩.		,	Coronary Artery Disease										2	
		b(		-	-							years	,	
N	Sequentially list conditions, if any, leading to immediate		C	Due to (or as a	consequ	ence ot):						years		
car Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Diabetes	Oue to (or as a S Melli	consequ tus	ence ot): Type I						years years		
	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest		Diabetes	Due to (or as a	consequ tus	ence ot): Type I								
Medical			Diabetes	Oue to (or as a S Melli	consequ tus	ence ot): Type I								
	resulting in death) Lest	cI	Diabetes D	Due to (or as a s Melli	consequence conseque	Type I ence ot):						years	5	
		cI	Diabetes D	Due to (or as a s Melli	consequence conseque	Type I ence ot):	given in Pert	l.		obacco use co	ntributs to	years	S of death	
	resulting in death) Lest Pert II. Other significant conditions	cI	Diabetes Diabetes	Due to (or as a s Melli	consequence conseque	Type I ence ot):	given in Pert	L		obacco use co ∕ss 2∑ No	ntributs to	years	S of death	
Dy r ily sicial ymedical	resulting in death) Lest	cI	Diabetes Diabetes	Due to (or as a s Melli	consequence conseque	Type I ence ot):	given in Pert	I.	101	′ss 2∏ No	ntributs to	years o the caus	ss of death	
	resulting in death) Lest Pert II. Other significant conditions	cI d tions contribut	Diabetes Diabetes Diabetes Diabetes Diabetes	Due to (or as a S Me11i Due to (or as a s a s a s a s a s a s a s a s a s	consequence conseque	Type I ence ot):	given in Pert	L		rss 2∏ No an autopsy	ntributa to	years the cause the bably 4 ere autops aliable primpletion	s of death Unknow	
100000000000000000000000000000000000000	Pert II. Other significant conditions.	cI d tions contribut	Diabetes Diabetes Diabetes Diabetes Diabetes	Due to (or as a S Me11i Due to (or as a s a s a s a s a s a s a s a s a s	consequence conseque	Type I ence ot):	given in Pert	I.	1 🗆 1	n autopsy med?	ntributa to	o the cause bebly 4 dere autopo aliable primpletion of death?	Unknown to be to b	
in the second se	Pert II. Other significant conditions.	cI d stions contribute al dise	Diabetes Diabetes ting to death but ease disease	Due to (or as a S Melli Due to (or as a Due to (or as a Due to to to as a Due to resulting in the tot resulting in	consequence conseq	ence ot):  Type I ence ot):	given in Pert	L	1 🗆 1	vss 2 No	ntributs to 3 Pro	o the cause bebly 4 dere autopo aliable primpletion of death?	s of death	
and the second s	Pert II. Other eignificant conditions and stage ren  Peripheral va  Bilateral low 25. Wes case reterred to medic	c. I d  tions contribut al disc scular er extr	Diabetes  ting to death but  ease  disease  remity a	Due to (or as a S Melli Due to (or as a Due to (or as a Due to to to as a Due to resulting in the tot resulting in	consequence conseq	Type I ence ot):  dertying ceuse	26. Plac		1 🗆 N 24a. Was a perfor	n autopsymed?	ntributs to 3 Pro	o the cause bebly 4 dere autopo aliable primpletion of death?	Unknown	
o completed by higher and and one	Pert II. Other eignificant conditions and the stage renumber of th	cI  d  tions contribut  al dise  scular  er extr	Diabetes  ting to death but  ease  disease  remity a	Due to (or as a second of the	tus conseque	Type I ence ot):  derlying cause	26. Plac Other: 4 N	e ot Death	24a. Was a performance of the conference of the	an autopsy med?  ses 2 № No	ntributs to 3 Pro	years  o the cause bebly 4  ere autops aliable primpletion death?  Yes 2	Unknown	
(	Pert II. Other eignificant conditions are sufficient conditions. The stage renumber of the stage releases are referred to medic examiner?  1 Yes 2 No.	cI d  tions contribut al disc scular er extr eel Hospi	Diabetes  ting to death but  ease  disease  remity a	Due to (or as a s Melli Due to (or as a s Melli Due to (or as a s to	tus conseque	ence ot):  Type I ence ot):  derlying ceuse	26. Plac Other: 4□ Ni njury at	e of Death ursing Hor	24a. Was a performance of the control of the contro	an autopsy med?	ntributs to 3 Pro	years  o the cause bebly 4  ere autops aliable primpletion death?  Yes 2	□ Unknown	
incompanies of a post-dimension of a	Pert II. Other eignificant conditions are sufficient conditions. The stage renular peripheral value of the s	c. I  d  tions contribut  al disc  scular  er extr  cel Hospi  ding stigation	Diabetes  Diabetes  ting to death but  ease  disease  remity a	Due to (or as a s Melli Due to (or as a s Melli Due to (or as a s to	tus conseque tus conseque in the unc	ence ot):  Type I ence ot):  derlying ceuse	26. Plac Other: 4 N	e of Death ursing Hor	24a. Was a performance of the control of the contro	an autopsy med?  ses 2 № No	ntributs to 3 Pro	years  o the cause bebly 4  ere autops aliable primpletion death?  Yes 2	□ Unknown	
incompanies of a post-dimension of a	Pert II. Other eignificant conditions in death) Lest  Pert II. Other eignificant conditions in the con	tions contributed al disesseular er extracel Hospitaling dispation do not be	ting to death but ease  disease  tal: 1   Inpatier  Ba. Date of Injun (Month, Dey)	Due to (or as a second of the	tus conseque tus conseque in the unce	Type I ence ot):  derlying ceuse  3 DOA	26. Plac Other: 4 Nijury at Vork?  Yes 2	e of Death ursing Hor	24a. Was a perior 1 Y (Check only one 5 Reside 28d. Describe h	an autopsy med?  es 2 № No ne) ence 6 □Ott ow injury occur	ntributs to 3 Pro	years to the cause bably 4 ere autopy aliable privaliable privalia	is of death Unkno sy tindings or to ot ceuse	
(	Pert II. Other eignificant conditions are suiting in death) Lest  Pert II. Other eignificant conditions are suiting in death Lest  End stage ren  Peripheral va  Bilateral low  25. Wes case reterred to medic examiner?  1   Yes   2   No  27. Menner of Death  1   Natural   5   Pency   Pen	cI d  tions contribut al disc scular er extr cel Hospi ding 28	ting to death but ease  disease  remity a tal: 1   Inpatier Ba. Date of Injun (Month, Dey	Due to (or as a second of the	tus conseque tus conseque in the unce	Type I ence ot):  derlying ceuse  3 DOA	26. Plac Other: 4 Nijury at Vork?  Yes 2	e of Death ursing Hor	24a. Was a performance of the control of the contro	an autopsy med?  es 2 № No ne) ence 6 □Ott ow injury occur	ntributs to 3 Pro	years to the cause bably 4 ere autopy aliable privaliable privalia	is of death Unkno sy tindings or to ot ceuse	
	Pert II. Other eignificant conditions are suiting in death) Lest  Pert II. Other eignificant conditions are suiting in death.  Peripheral va  Bilateral low  25. Wes case reterred to medic examiner? 1 yes 2 No  27. Menner of Death 1 Natural 5 pend invest 2 Accident 3 Suicide 6 Could determine are suiting and suiting are suiting are suiting and suiting are sui	cI d  tions contribut al disc scular er ext; cel Hospi ding stigation d not be rmined 28	ting to death but ease disease tal: 1   Inpatier a. Date of Injun (Month, Dey building, etc.	Due to (or as a second of the	tus conseque tus conseque in the unc in the unc inthe un	Type I ence ot):  Type I ence ot):  derlying ceuse  3 DOA 28c. If the property of the property	26. Plac Other: 4 Nijury at vork? Yes 2 Ce	ursing Hor	24a. Was a performance of the control of the contro	an autopsy med?  Ses 2 No ne)  ence 6 □Ottoow injury occur  street end Number, Stete)	ntributs to 3 Pro  24b. W av cc ot 1 [	years  o the cause bably 4  fere autopo aliable pri mipletion of death?  Yes 2	is of death Unkno sy tindings or to ot ceuse	
	Pert II. Other eignificant conditions are suiting in death) Lest  Pert II. Other eignificant conditions are suiting in death.  Peripheral va  Bilateral low  25. Wes case reterred to medic examiner? 1 yes 2 No  27. Menner of Death 1 Natural 5 pend invest 2 Accident 3 Suicide 6 Could determine are suiting and suiting are suiting are suiting and suiting are sui	tions contributed al discontributed al discontributed al discontributed al discontributed al discontributed al Examines:	ting to death but ease  disease  tal: 1   Inpatier  Ba. Date of Injun (Month, Dey)  Be. Place of Injun building, etc.	Due to (or as a second of the	tus conseque tus conseque in the unc in the unc inthe un	Type I ence ot):  Type I ence ot):  derlying ceuse  3 DOA 28c. If the property of the property	26. Plac Other: 4 Nijury at vork? Yes 2 Ce	ursing Hor	24a. Was a performance of the control of the contro	an autopsy med?  Ses 2 No ne)  ence 6 □Ottoow injury occur  street end Number, Stete)	ntributs to 3 Pro  24b. W av cc ot 1 [	years  o the cause bably 4  fere autopo aliable pri mipletion of death?  Yes 2	is of death Unknow sy tindings or to ot ceuse	
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	Pert II. Other eignificant conditions are suiting in death) Lest  Pert II. Other eignificant conditions are suiting in death.  End stage ren  Peripheral va  Bilateral low  25. Wes case reterred to medic examiner?  1	tions contributed al disesseular ex extra Hospital Hospital ding sligation do not be remined 28	ting to death but ease  disease  tal: 1 Inpatier Ba. Date of Injung (Month, Dey) Be. Place of Injung building, elc.	Due to (or as a second of the	tus conseque tus conseque in the unc in the unc inthe un	ence ot):  Type I ence ot):  derlying ceuse  3 □ DOA   28c. Ir   11   12   12   12   12   12   12   1	26. Plac Other: 4 Nijury at Vork? Yes 2 See	e of Death ursing Hor I No	24a. Was performed to the control of	an autopsymed?  as 2 № No  ane)  ence 6 □Oth ow injury occur  itreet end Numb ause(s) and m fale end place.	ntributs to 3 Pro  24b. W av cc ot 1 [  ther (Special red  ber or Run  anner as s end due to bet (Month,	years  o the caus  bably 4  fere autopo aliable pri mpletion odeath?  Yes 2  fy)  al Route N  stated. o the caus	ss of death Unknow sy tindings of ceuse XNo	

DHMH 16 Rev 6/95

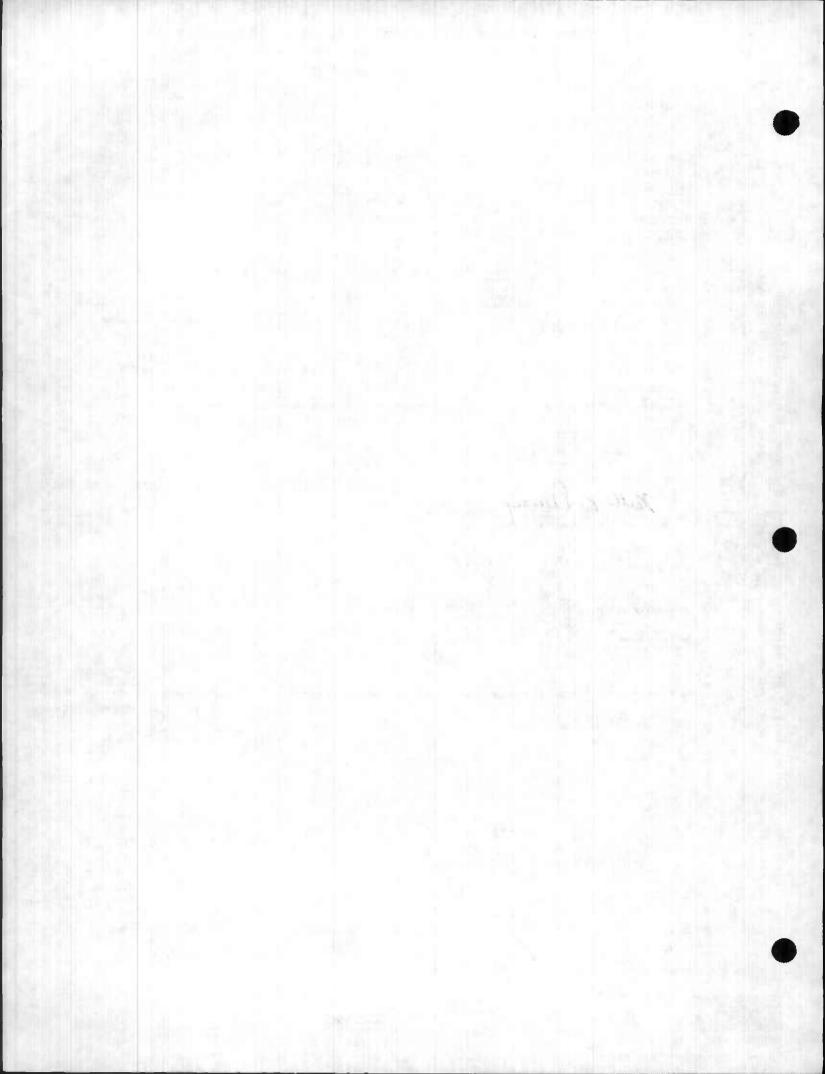


B.K.S

DANIEL J. LOVELY State of Maryland / Department of Health and Mental Hygiene

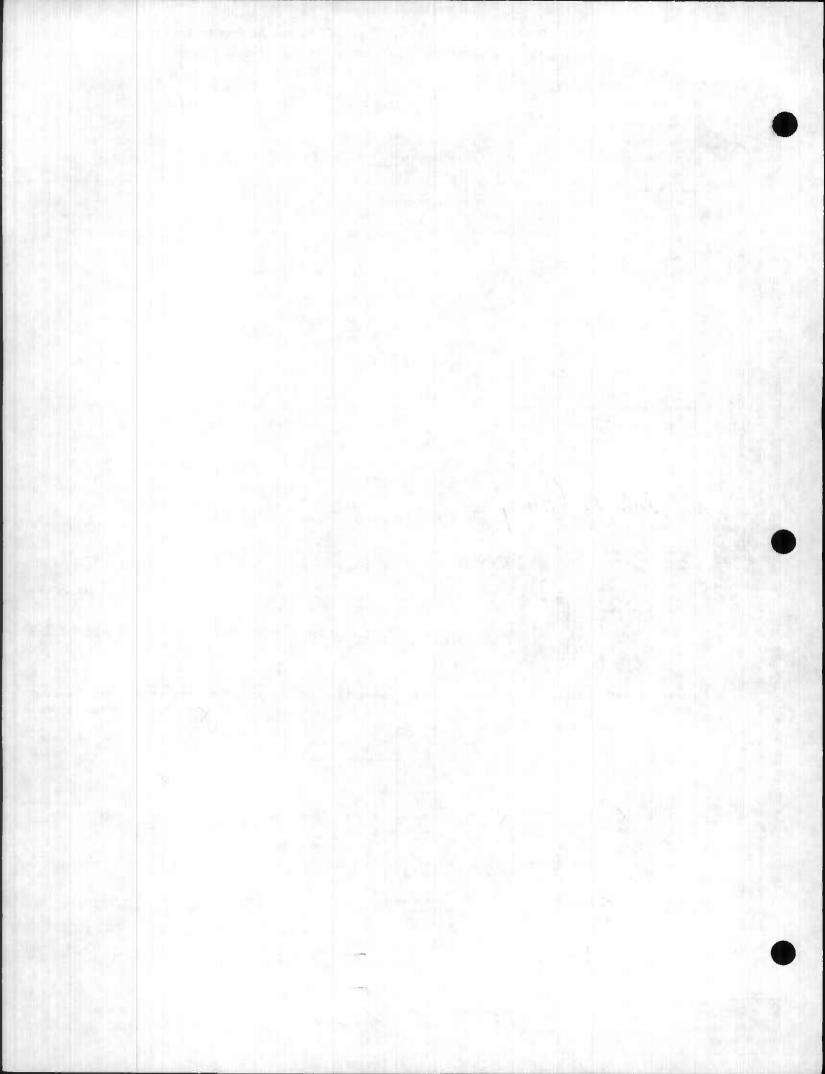
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U	NKNOMN 0	0-272		Ce	rtificate of	Death		Reg. No.		
		1. Decedent'e Neme (First, Middle,	Last)				2. Dete of De Month	eth Dey	Yeer	3. Time of Death
(Q)	Physician /Medical	DANIEL	JOSEPH LO	OVELY			SEPT.	30, 200		0227 AM
	Examiner	4a Facility Neme (If not institution, 605 WEST JOP				4b. City, Town	n, or Location of Deet N	1	of Deeth	Ξ
	Funeral Director	5. Social Security Number 216–90–0867 Usuel Residence of Decedent	5. Sex 7. Age (În yı 1 ■ 34	s. lest birthday, Yrs.	Months Day		Min. 8. Dete of Bi	th ey, Yeer) 1, 1966		lece (Stete or Foreign try) rida
	land	10a. Stete 10b. County	10c. 6	City, Town or L	ocation			700	10	Od. Inside City Limits
	Meny To to	Maryland Balt	imore	Tow	son					1 ☐ Yes 2 No
	or 28	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Coun	itry?
	th wil	11 Danforth Cou	rt		21	204		USA		
Maryland 21215-0020	poemit. Pages 1 and 2 should be filed within 72 hours effer death with the Meryland Deperment of Health and Mental Hygiene. Deperment of Health and Mental Hygiene.  Important: If them 27 is marked other than "natural", or flems 23a or 28a-f show many injury or other traumatic event, the Medical Examinar must be notified at once.  To Be Completed by Funeral Director	11. Meritel Status  1 Never Merried 2 Marrie 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces?  1 Yes 2X No if Yes, Give Yeer or Detes:		Was Decedent of If Yes, specify Cu 1☐ Yes 2☐No		n? (Specify Yes or No Puerto Rican, etc.)	Specify	ck, White, o	etc.
20-0	72 ho	15. Decedent's	Education	16e. Dece	dent's Usuel Occ	upation	of working	16b. Kind of Bi	usiness/Inc	dustry
21	be filed within 72 ho tal Hygiene. d other than "naturi event, pr. Medical. Be Completed	(Specify only highest Elementery/Secondary (0-12)	College (1-4or 5+)		kind of work don DO NOT use reti	red)	n working			
7	No in the state of	12	1	Che	f	40.14-0-4	Alexander Alexander	Culina		
and	Be verified	17. Fether's Neme (First, Middle, L. Robert E. Love					s Name (First, Middle Tean F. Do		10)	
Z	should be and Mental armarked or urmatic eve	19e. Informant's Name/Reletionshi	*	19h Meili	ing Address (Stre		or Rural Route Numb		Stete Zin	Code)
	end 2 s Balth er n 27 is er trau	Amy Jo Lovely/W					h, Timoni			
timore,	f Head that the other	20e. Method of Disposition		. Plece of Disp	osition (Neme of metory or other p	lace)	Dete	20c. Location -	City or To	wn, Stete
E	Pages nert: If he iry or o	1 Burial 2 Cremetion 3	B □Removel from Stete scify)		y Cremat		10/2/00	Salisb	oury,	MD
Balti	permit. Depertri	21. Signeture of Funeral Service Li	censee		Home Professional Association					
6		23a. Pert1. Enter the disease, or c shock, or heert feilure. List o	omplications that caused the de							Approximete Intervel Between
	Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in deeth)	e. Multi-	(or es e conse						Onset and Death
x 68/60,	The lew requires that the death certificate be executed at the best signed by the attending physicien end page 2 should be deteched for use as the bunal-transit completed by Physician/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Last	c	(or es e conse						
F.O. Box	v requires thet the death ce been signed by the attendir should be deteched for use leted by Physician/	Part II. Other significant condition	contributing to death but not n	esulting in the u	underlying cause (	given in Pert I.		tobacco uee co Yes 2□ No	ontribute to	the cause of death?
or Vital Records,	The lew requires the cate has been signed pege 2 should be completed by							s en eutopsy ormed?	COL	ere eutopsy findings aileble prior to mpletion of cause deeth?
ř	The lev te has bege 2	Manager Lines					100	Yes 2□No	10	Yes 2 No
Ita	slan: entifica ector, l	25. Wes case referred to medical examiner?		of Deeth (Check only	one)					
Division of V	Physician: r this certific ral director,	Yes 2 No  27. Menner of Deeth 1 Naturel 5 Pending investige 2 Accident 3 Suicide 6 Could no determin  29a. Certifier 1 Certifying	t be 290 Place of Injury At	28d. Describe Sufy 28f. Location City or To	bow injury occur  The Company of the	ber of Aura	to Jope			
	the H thin 24 the F mplete	one)	end menner steted.							
	0 1 × 10	29b. Signeture end title of certifier	11 11		100	29c. License number  29d. Date signed (Month, D SEPT. 30,				
	in after	Medne 1	ar & Is					OHI I	- 50,	2000
	10 line	30. Neme and address of person w	. 10			Raltin	nore, Mary	land 21	201	
	State	31. Date filed (Month, Day, Year)	32. Pjegistrer's Sig	nature /	, orreer	, DOT LI	iore, mary	JOIN 212	201	
	Registrar		000 Penera		Spark	61				



State of Maryland / Department of Health and Mental Hygiene 00 32829

				Ce	rtificate	of D	eath			Reg. No.		
		1. Decedent's Name (First, Middle, La	nst)						2. Data of De		- 1-5	3. Time of Death
	Physician	HERBERT	WHITE	LEX	JEUNE				OCTOBE:	R 1,2000	Year	4:16 AM
	/Medical Examiner	4a Facility Nama (If not institution, gin PENINSULA REGION		CENTER		4b		wn, or Lo	ocation of Deaff		of Deeth	1.10 /11
-	Funeral	5. Social Security Number 6.	Sax 7. Aga (	(In yrs. last birthdey		Yeer Days	If Under Hours		8. Date of Bir (Month, Da	th y, Year)	9. Birthp	olaca (Steta or Foreign
	Director	130 10 0213	6	7 Yrs.					March	10,1933	Loui	siana
	pue *	Usual Rasidence of Decedant  10a. Sfete 10b. County	1	IOc. City, Town or L	ocation						1	Od. Inside City Limits
	vith the Maryl or 28s-f sho be notified	Maryland Wicomi	co	Salisbu	ıry							1 ☐ Yas 2X No
	or 21	10e. Street and Number			10f. Zip C	Code				10g. Citizen of V	Vhet Cour	ntry?
	\$ 8 E	812 Gettysburg A	ve.			1804				USA		
120	hours after death with the Maryland urel", or flems 23s or 28s-4 show Examiner must be notified at ed by Funeral Director	11. Merital Status  1 Never Married 2 Merried  3 Wildowed 4 Divorced	12. Was Dacedant Ev Armed Forces? 1 ☑ Yas 2 ☐ No If Yas, Giva Yaar or Datas:	ar in U,S. 13. Army	Was Deceda If Yas, specif 1 ☐ Yas 2		panic Ori , Maxicar Specify:	gin? (Spe i, Puarto	ecify Yes or No Rican, atc.)	Specify	k, White,	ean indian, etc. lite
8	"natural",	15. Decedent's E		16a Dec	edant's Usual	Occupa	fion			16b. Kind of Bu	usinass/in	dustry
21215-0020		(Specify only highast gr	ada completed)	(Giv	edant's Usual e kind of work DO NOT use	dona du ratired)	uring mos	t of worki	ing	100.11.100.01		
212	filed within Hygiena. The then "the then "the then "the then "the then "the then "the the the the the the the the the the	Elementary/Secondary (0-12)	Collaga (1-4or 5+)		aftsma					Build	lina	
	= 1 4 5 0	17. Father's Nama (First, Middla, Last	)		. CL COMO		18. Mothe	ır's Nama	a (First, Middla	Maidan Sumam		
lan	Mental H Mental H arked off artic ever	Jesse Lejeune					Iv	alin	ne Bake	er		
Maryland	2 should and Men is marke summite	19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ling Addrass (	Street a				er, City or Town,	Stata, Zip	Code)
X	end 2 selth at 27 is er trau	Donison Lejeune/	Son	ve.	Salis	oury, MD	218	04				
e,	ーエミラ	20a. Mathod of Disposition		20b Place of Disc	osition (Nema	a of			Dete	20c. Location -		
Baltimore,	thent of the start: If He silvey or o	1 X Burial 2 Cramation 3 [ 4 Donation 5 Other (Speci	(y)	Springhil		Garc	dens		0/5/00	Hebron	n, MD	
Bal	Department Department Important: I any Injury o	21. Signature of Funaral Service Line	Trune			ay I	runer	al H	Nome Pro		ssociation	
		23a. Part1. Enter the disaasa, or conshock, or heart failure. List only	plications that caused the	na daath. Do not a	ntar tha moda	of dying	, such es	cardiac o	or raspiratory a	rrast,		Approximata Intervel Between
	Physician											Onset and Death
rá	/Medical	Immediate Ceuse (Final disaesa or condition	ahma.	nene	01	2	II	T	ract	_		50
	Examiner	resulting in death)	a	ue o (or as e cons	equance of):							0
-	D E		. Who	role.	DANO	L	ul					month
	certificate be axecuted reling physician and use as the bunial-transit and AMedical Examiner	Sequentially list conditions,	D.	ua lo (or as a conse	quence ol):							
0	ian e unial-	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury	an	~D00	21 -	(	ON	100	am			enknown
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	ing pt	Tubuling III doubling East										
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	within 2 To the comple	29b. Signeture and title of vertiller			29d. Data signe	d (Month,	Day, Year)					
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State of Maryland / Department of Health and Mental Hygiene

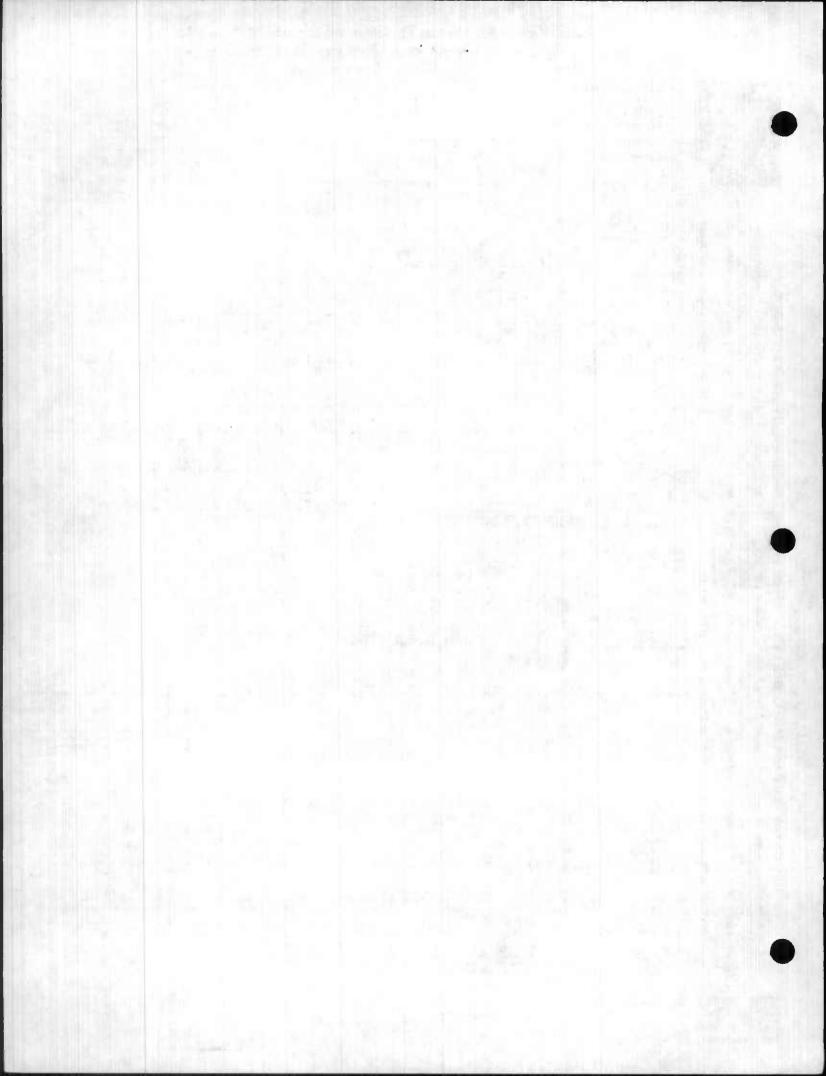
Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Dey **Physician** September 30, 2000 Ballard 0618 DOUTNE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street and number) Examiner SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER 7. Age (In yrs. last birthday) It Under 1 Yeer If Under 24 Hrs.

Months Devs Hours Min. 5. Sociel Security Number Birthplace (State or Foreign Country) **Funeral** Deys Hours 10 M 20 F Yrs. Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show Examiner must be nothled at 1 Yes 2□No Somerse **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 187 238 lterns : A Race - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merital Status Bleck, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 "natural", or 1 Yes 20 No Specify Specify: Black þ 3 Widowed 4 □ Divorced Be Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DQ NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) entery/Secondery (0-12) College (1-4or 5+) al Hygiene. Johnson Meat 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) permit. Pages 1 and 2 should be t Department of Health and Mental I Important: If Item 27 ie marked of eny Injury or other traumatic eve 25 19e. Informent's Neme/Relationship (Type, Pript) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Edwa Bac Brooke Wes tour daughter 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Wastley Ceretary 10-5-00 4 ☐ Donetion 5 ☐ Other (Specify) Westover Md 22. Name and Address of Facility
B CNASC 5 miles 21. Signeture of Fogeral Service Licansee Homo ennic Pio. Box 331 Pocomoke 23a. Pert1. Enler the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Betw Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical STATUS EPILEPTICUS **Examiner** Due to (or es a consequence of): Examiner CEREBRAL HEMORRHUNGE Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last MYELOFIBROSIS Physician/Medical Due to (or es e consequença of Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No this certificate Division of Vitai To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified Be 25. Wes case reterred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1 DNeturel 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: A 2 Accident 28t. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, tectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and pleca, and due to the cause(s) and menner stated. 29e Certifier 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signeture end title of certifier M.D 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) PINEBLUFF SALISBULY M.D FOLASAMDE, M 32. Registrer's Signeture State Registrar

DHMH 16 Rev 6/95

1337



AGNES THOMAS MORRIS 28 2045 Sept 2000 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Memorial Hospital Easton Under 24 Hrs. Talbot If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthpiaca (Stete or Foraign **Funeral** 10 M 2 KF Days Months Hours MARYLAND 220-12-0541 92 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heelih and Mental Hygiene. The important: If them 27 is marked other than "natural; or items 23a or 23a-f ehow any injury or other traumatic event, the lead of East item man be notified as 1 Yes 2 □ No Director TALBOT EASTON 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 201 FEDERAL ST. 21601 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ØNo If Yas, Give Year or Datas: 11 Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Reca - Amarican Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married WHITE 1 Yes 2 No Specify: Maryland 21215-0020 Specify þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) College (1-4or 5+) SALES CLERK VARIETY STORE 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be JANE L. HARPER WILLIAM MARTIN THOMAS 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) THELMA M. FLUHARTY/DAUGHTER 7901 PEANECK RD, ST. MICHAELS, MD 21663 Baitimore, 20b. Place of Disposition (Name of cematery, cremetory or other pleca) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State WASHINGTON UNITY CEMETERY 10-2-2000 HURLOCK, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funaral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 23a. Pen 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner hysician and the burial-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequença of) Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the 1 Yes 2 No signed by 3 Probably 4 Unknown Division of Vital Records, by 24b. Wara autopsy tindings available prior to complation of causa of death? Completed 24a. Was an autopsy certificate hes 2No 1 Yas 1 Yes 2 No after deeth.

Olrector: After this certific 25. Was case referred to medical axaminer? Be 26. Place of Death (Chack only one) Hospitat: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide To the Hospital of within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, daath occurred at the tima, date and place, and dua to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, date and place, and dua to the cause(s) end manner stated. 29a. Certifier 29b. Signature and title of certifian 29c. License number 29d. Data signed (Month, Day, Year) 000 30. Nama and addrass of person who completed causa ot death (from 23a) (Type, Print) WILLIAM H. WOOD, JR M.D. 505 IDLEWILD AVE., EASTON, MD 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State OCT 0 2 2000 Registrar **DHMH 16 Rev 6/95** 

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

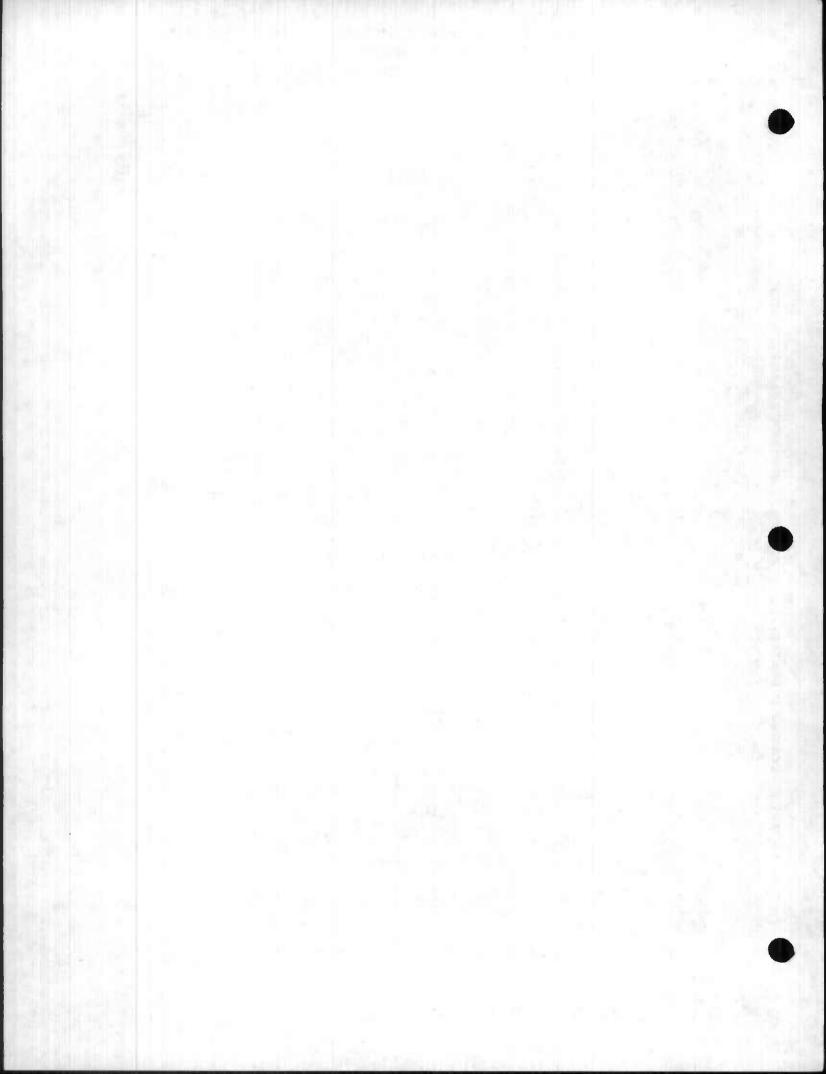
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3. Time of Death

Vaar

1. Decedent'a Nama (First, Middle, Last)

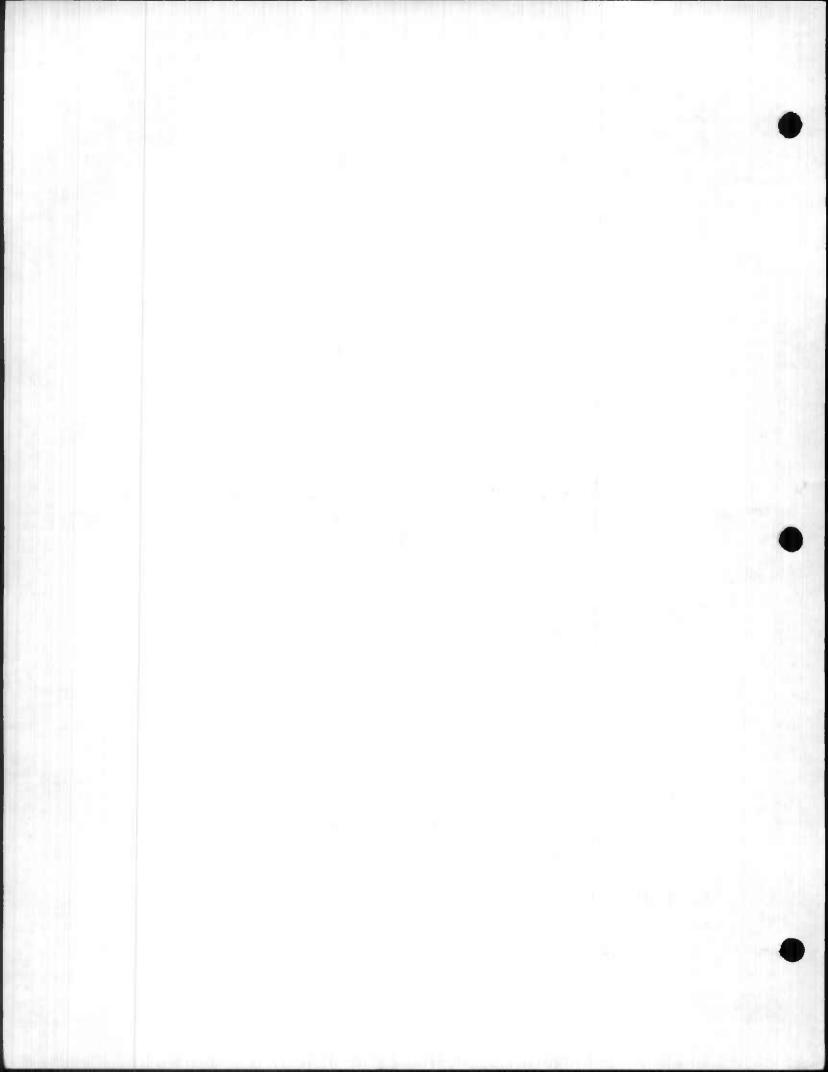
**Physician** 



State of Maryland / Department of Health and Mental Hygiene

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						Ce	rtificate	of	Death			Reg. No.		
Physicia: /Medica	_	1. Decedent's Nama (First, M Ira B. Mullis									2. Data of Do		0 0 0 O	3. Tima of Death 535pm
Examine		4a. Facility Neme (If not institu			imber)				4b. City, To Silve		ocation of Deal		ty of Daeth	
Funeral Director		5. Social Sacurity Number 505-12-8544		Sax 1 ☐ M 2 ☐ F	7. Aga (In yrs.	/ast birthday)	If Under 1 Y Months D	ear	If Under Hours	24 Hrs. Min.	8. Data of Bi (Month, D Aug 2	rth ay, Year) 1921	9. Birth	place (State or Foreig ntry)
		Usuel Rasidanca of Dacadan												
a-f shov	ctor	10a. Stata 10b. Cou MD Mon		nery		ty,Town or Lo lver S								10d. Insida City Llmi 1 ☐ Yas 2 ☐ N
3a or 28	il Director	10e. Street and Number 14700 Claude	La				10f. Zip Co 2090!					10g. Citizan o		*
	by Funeral	11. Marital Status  1 Naver Marriad 2 Nover Marriad 2 Nover Marriad 2		If Yas, Gi	edant Evar in U orcas? 2 No iva Dates: 43-4		Wes Dacedant If Yas, specify		dispanic Orl an, Maxicar Specify:		ecify Yas or No Rican, atc.)		aca - Amari ack, Whita,	can Indien, , atc.
n natural Medical E	Completed	15. Dece (Specify only his Elemantary/Secondary (0-1	dant's E	ducation ade completed)		16a. Decar	dant's Usuai O kind of work d DO NOT use n	lone	during mos	t of work	ing	16b. Kind of Johns	Businass/Ir	ndustry ins Univ.
Hygiene. other than	Eo	and the state of t		Coilege (	-	Elect	trical	En	ginee	r		APL		
be fill H d out	To Be	17. Fathar's Nama (First, Mide Ira B. Mulli:		)					18. Mothe		a (First, Middle Duckett	, Maiden Sum	ame)	
		19a. Informant's Name/Relationship (Type, Print)  Janet Mullis /Wife  19b. Mailing Addras 14700 Cla 20a. Mathod of Disposition  20b. Place of Disposition (Ne												
		Janet Mullis /Wife 14700									Oct 3 2000	20c. Location Belts		
		21. Signature of Funaral Sarv	ica Line	nsog/ (	14	22	Name and A Rapp Fi 933 Gi	ddra une	eral d	Cr ue		Servi Spring		_
Selician and ding physician and assess the burdel-frensit aminer	edicai Examiner	23a. Peril. Entar tha disease shock, or haart failura. Immadiata Cause (Finel disease or condition rasulting in death)  Sequentially list conditions, if any, leading to immadiate cause. Entar Undarlying Causa (Disease or injury thet initiated avants rasulting in death) Last	oras a consac	t quance of): failure quanca of):					irrasi,		Approximeta Interval Betwaan Onsat and Deeth			
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5 6	Completed by											an autopsy ormed?	e/ e/	lara autopsy findings vallable prior to empletion of causa death?
page 2	E										1 🗆	Yes 2☐No	1	□Yas 2☐No
	a)	25. Was case refarred to mad examinar?	ical						26. Piace	of Daet	h (Check only	one)		
his di		1 ☐ Yas 2 ∰ No  27. Manner of Daath 1 ☑ Natural 5 ☐ Per		28e. Deta (Mon		ER/Outpatier 28b. Time of injury	28c.		y et rk?			idence 6 🗆0 how Injury occ		fy)
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Funer Funer etely fill		29a. Cartifiar 1 XCertir (Check only one) 1 Medic	ying Ph	yalclan: To tha niner: On tha b and man	best of my kno asis of axamina nar stated.	wledge, death tion and/or in	occurred et the	ha tir my o	ma, data an opinion, daa	d placa, th occur	and dua to tha red at tha tima,	causa(s) and a data and place	mannar as s a, and dua t	stated. to the cause(s)
Tothe comple		29b. Signatura and unit of cen	ifier	0	Donal	) u	29c. Li		a numbar			29d. Data sign	ned (Month,	Day, Year)
		30. Nama and address of pers			CONTRACTOR OF THE PARTY OF THE			sil	Lver S	Sprin	ng, MD	20902		,
State	e r	31. Date filed (Month, Day, Ye			egistrer's Signa		Spor							



State of Maryland / Department of Health and Mental Hygiene

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32833

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Year October 1, 2000 **Physician** Lawrence Payne Monnier 1220pm /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner 15005 Good Meadow Ct. Gaithersburg Montgomery 6. Sex 1 → M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sep 6, 1942 Birthplece (State or Foreign Country)
 MI 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 58 Yrs. Months Deys Hours 379-42-0575 Director Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No MD Montgomery Gaithersburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23s or 15005 Good Meadow Ct. 20878 United States permit. Peges 1 end 2 should be filed within 72 hours after death a Department of Health and Mentel Hygiene.
Important: if them 27 is marked other than "natural", or thema 23e any injury or other traumatic event, the Men Funeral 12. Was Decedent Ever In U,S.
Apped Forces?
1 ☐ Yes 2 ☐ No
If Yes, Giva
Yeer or Detes: 66-88 14. Race - American Indian, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: te by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Defense Travel Elementery/Secondary (0-12) College (1-4or 5+) Systems Engineer 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lawrence Edward Monnier Thelma Pearl Payne 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 15005 Good Meadow Ct., Gaithersburg, MD 20878 Diane Monnier /Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 Buriel 2 Cremation 3 Removal from Stete 20c. Location - City or Town, State Oct 5 Beltsville, MD Chesapeake Crematory 2000 4 ☐ Donetion 5 ☐ Other (Specify) 22 Nama and Address of Facility
Rapp Funeral & Cremation Services 933 Gist Avenue Silver Spring, MD 23a. Partt. Enter the disable, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart league. Let only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediete Cause (Finel disease or condition rasulting In death) 7 months Metastatic Lung Cancer Examiner Due to (or es e consequence of): Examiner The lew requires that the death certificate be executed Sequentially list conditions, if eny, laading to immediate ceuse. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or es a consequence of): and Box 68760, physician Physician/Medical Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? P.0. Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Pleural Effusion 1 Yes 2 No 3 Probably 4 Unknown signed by Division of Vital Records, þ 8 24b. Were eutopsy findings available prior to complation of cause of death? page 2 should Be Completed 24a. Was en eutopsy performed? certificate hes 1 Yes 2 No 1 Yes To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director; After this certifica after deeth.

Director: After this certification of in by the funeral director, 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 28a. Deta of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending investigation 1 Natural 1 Yas 2 No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 6 Could not be datermined 28a. Plece of Injury - At homa, ferm, straet, factory, office building, atc. (Specify) filled in by 4 Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and mannar es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and menner steted. 29e. Certifier completely (Check only one) 29b. Signeture and title 29c. License number 29d. Date signed (Month, Day, Year) 0101-057098 20 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) Patrick F. Fogarty M.D. Bldg.10 Rm 7C103 9000 Rockville Pk, Bethesda, MD 20892 OCT 6 4 31. Dete filed (Month, 32. Registrer's Signature State 2000 south Sepera Registrar

#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #6,10/2/2000, BMW, Montg. Co. Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** MOHAMEDNOR BDELGAFOR 2000 /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENERAL Hos. C n yrs. last birthday) H Undar 1 Year | Moriths Days Columb HOWARD OUNTY (9 ENER. 7. Aga (In yrs. last birthday) HOWAR If Undar 24 Hrs. 9. Birthplaca (Stata or Foraign Country) 5. Social Security Number **Funeral** Hours 1) M - 10 T Unknown Yrs. Sudan Director Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Nama 23a or 28a-f show 1 ☐ Yas 2 ☐ No Director Maryland Howard Columbia event, the Medical Examiner must be notifi-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5208 Cedar La. 21044 Sudan Funeral 12. Was Decedent Evar in U.S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amarican indian. 11. Marital Status Black, Whita, atc. 1 Navar Marriad 2 Married b 1 ☐ Yas 2€ No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decadant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) Merchant N/A Trader 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Fathar's Nama (First, Middla, Last) nd Mental marked o Mohamednor Awad Zeinab M. Ayob 19a. tnformant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Health Jam 27 I Mohamed A. Mohamed-Son 5208 Cedar La., Columbia, Md. 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 12 Burial 2 Cramation 3 Ramoval from Stata ŏ 9 9-30-2000 Adelphi, Md. 4 ☐ Donation 5 ☐ Other (Specify) Wash. Cemet. 22. Name and Addrass of Facility Universal II Mortuary Inc. 21. Signature o Funaral Sarvice Licensaa Ì 411 Kennedy St, N.W., Wash, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical 4mm cg Examiner Due to (or as a consequenca ot): Physician/Medical Examiner use as the bunial-transit Sequantially list conditions, if any, leading to immadiate causa. Enfar Undarlying Cause (Diseasa or Injury that initiated avants Dua to (or as a consequence of): and Dua to (or as a consequence of) rasulting in death) Last Part II. Other significant conditions contributing to death but not rasulting in tha undarlying causa given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown andlongopalta þ 8 24b. Wara autopsy findings evailabla prior to completion of causa of death? Medical Certification: To Be Completed 24a. Was an autopsy performed? After this certificate has 1 Yas 2 No 1 ☐ Yas 2 ☐ No after death. Director: After this certification by the funeral director, 25. Was casa rafarred to medical 26. Placa of Daath (Check only one) 1 Yas 2 No Hospital: 1 ☐ Impatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 28d. Dascribe how injury occurred 27. Manner of Death 28c. tnjury at Work?

30. Nama and addrass of person who complated causa of death (Item 23a) (Typen Print)

5 Panding invastigation

6 Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Tima of Injury

28a. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify)

1 Yas 2 No

LAUREL

281. Location (Street and Number or Rural Routa Number, City or Town, State)

29a, Cartifier

1 Matural

2 Accidant

4 Homicide

3 Suicida

1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signatura end title of certifier

29c. Licansa number

29d. Data signed (Month, Day, Year) 2000

20708

State

31. Data filed (Month, Day, Year) 2000 OCT Ü

14333 dans 32. Registrar's Signatura

Registrar

72 hours after

filed within

ahould be

Pages ъ

The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

of Vital

Division

Hospital or Attending Physician:

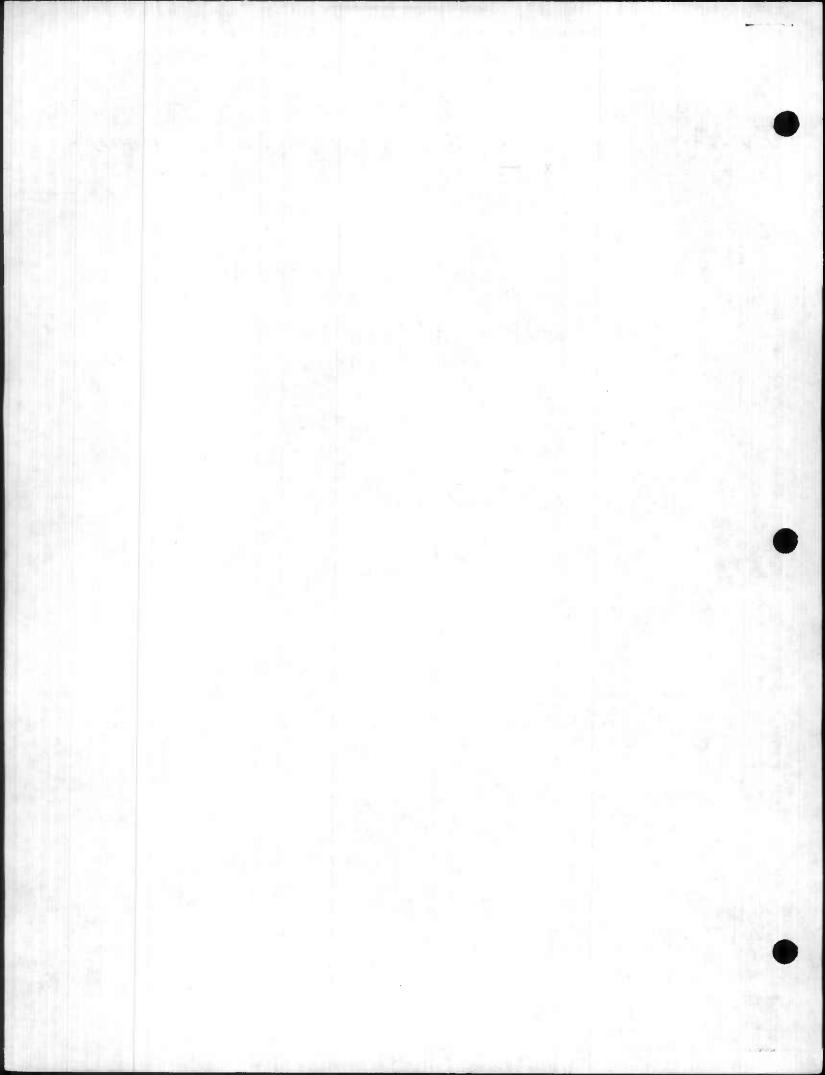
To the

within 24 hours after de To the Funeral Directo completaly filled in by th

21215-0020

Maryland

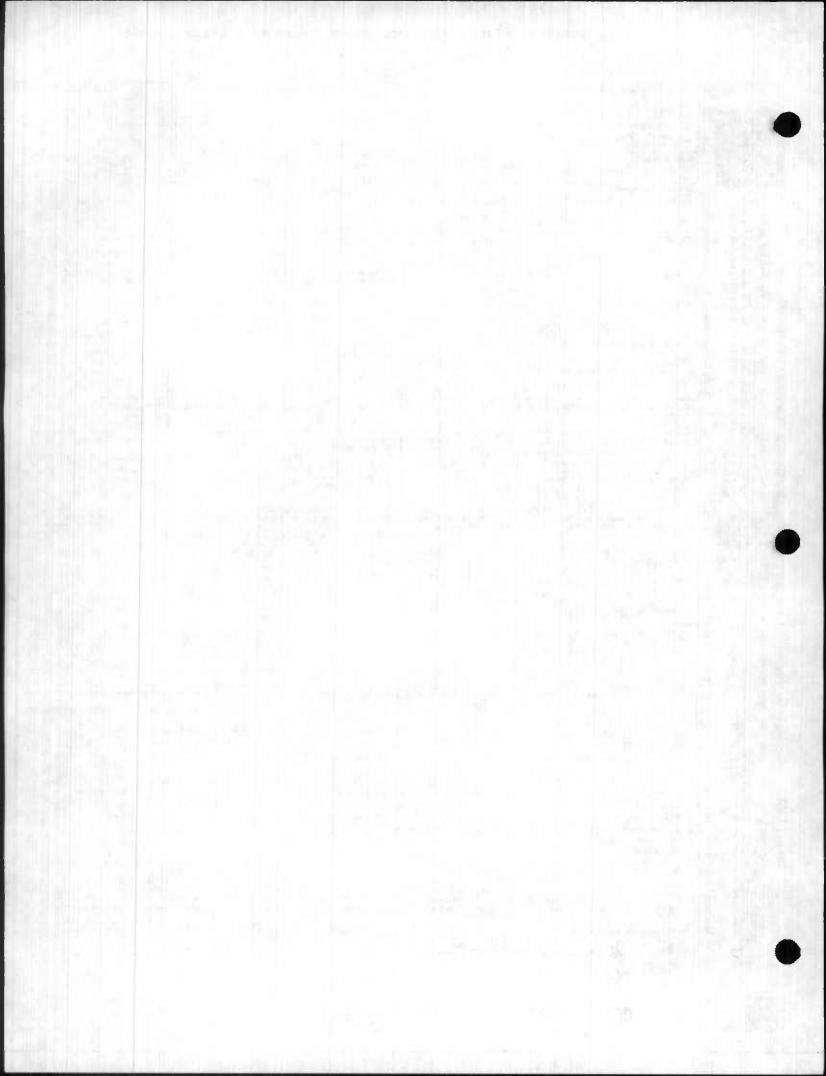
Baltimore,



State of Maryland / Department of Health and Mental Hygiene 00 32835

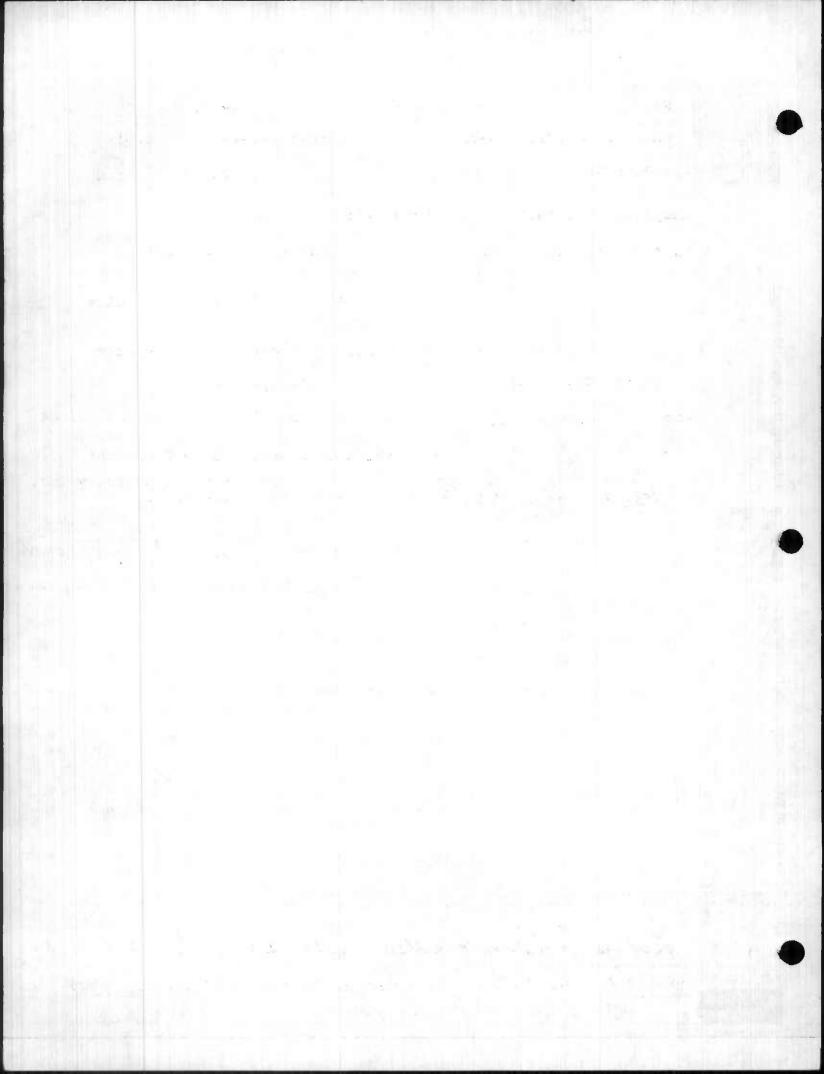
					Ce	rtificat	e of	Death			Reg. No.		C	00
		1. Decedent's Name (First, Middle	Last)							2. Data of De Month	ath Day	Year	3. Tim	a of Death
92	Physician /Medical	Eustaquio Mej	ia							Octobe		000	10	42am
	Examiner	4e Fecility Nama (If not institution, Holy Cross Hos		mber)	11/31			4b. City, To Silve		cation of Deeth		of Death	У	
	uneral irector	5. Social Security Number 219-90-2566	6. Sex 1☐ 1 2 □ F	7. Aga (In yrs.	80 Yrs.	Months	1 Yaar Days	If Undar Hours	24 Hrs. Min.	8. Dete of Bir (Month, De Nov 1	th y. Yeer) 1919	9. Birthpl Count CUZC	(m)	ete or Foreign Peru
		Usual Rasidence of Decedant												
Marylen	ar show	MD Montg	omery		ity. Town or L neaton	ocation						10		le City Limits Yes 2 No
h with the	is or 28a-fs	10e. Street and Number 11817 Idlewood	Rd			10f. Zip	Coda 906				10g. Citizan of United			
within 72 hours efter death with the Marylend ene.	then "natural", or itema 23e or 28e-f show the Medical Exemples must be notified at ompleted by Funeral Director	11. Maritel Stetus 1 Nevar Married 2 Marrie 3 Widowed 4 Divorced	Armed Fo	2 No va	J,S. 13.	Was Deced If Yas, spec				ecify Yes or No Rican, etc.)		ca - America ck, Whita, a spani	atc.	n,
d within 72 hours of gione.	t, tre Hedrell Completed	15. Decedent	t grede completed)		(Give	edent's Usua e kind of wo DO NOT us	rk done	oation during mos			16b. Kind of B Peru G	usinass/Ind	lustry	t
0 6		Elemantery/Secondary (0-12)	College (	1-40r 5+)	Mili	tary	Pol:	ice						
should be filed within	T is marked other treumatic event, To Be C	17. Fathar's Nama (First, Middle, L Demetrio Meji						18. Moths		(First, Middle, Quispe	Meiden Sumer	me)		
P P	- 9							Code)						
Dearth Feges 1 and 2 Department of Health 8	important: If ham 27 any Injury or other to once.	19a. Informent's Neme/Relationship (Type, Print)  Jesus Mejia /Son  19b. Meiling Address 4318 Aspe  20a. Mathod of Disposition 1 Burial 2 Cramation 3 Amamovel from Stata 4 Donetion 5 Other (Specify)  19b. Meiling Address 4318 Aspe								Oct 14 2000	20c. Location Madre			
pemit. Pege Department	Importa eny inju pace.	21. Signature of Funeral Service L	Logosoo H	/	2	Rapp 933		eral Aven	& Cre		nation Services lver Spring, MD			
Phy	sician	23a. Part1. Entar the disaasa, or shock, or heartuailura. List o	complications that conly ona causa on a	caused the dea	th. Do not er	ntar tha mod	a ot dyi	ng, such es	cardiac o	or raspiratory a	rrast,		Approxi Intarval Onset e	imeta Between and Daeth
/ /M	edical miner	Immediata Causa (Final disaasa or condition rasulting in daath)	Aspi	iration	pneum	onia		350					Min	utes
P	al sit		Dys	Dua to ( phagia	or as a conse	equance ot):								
e axecut	unal-transit	Sequentially list conditions, if any, leeding to immadiate causa. Enter Underlying	Stro		or as e conse	equance of):								
certificate be asscuted	attending physicien end for use as the burial-transit clan/Medical Examir	Cause (Diseese or injury that initiated avants rasulting in death) Last	c	Due to (	or es a conse	quance of):			-				5	
death	for us													
hat the	by the ached	Part It. Other significant condition	ns contributing to d	eath but not ra	sulting in the	underlying o	ause gi	ven in Pert i	i.		tobacco use co Yes 2□ No			use of death? 4 ☐ Unknown
ne lew requires that	should be									24a. Was	an autopsy ormed?	ava cor	ailable pi	psy findings rior to ot causa
The lew	page 2									10	Yes 2 No			2 No
	certificate rector, pag	25. Was casa retarred to medicel axaminer?							e of Death	(Check only	one)			
Physician:	this ce ral dire	1 □ ¥ as 2 □ No	-	•	ER/Outpatie		)A		-		dence 6 □Ot		0	
2	v: After the funeral tation:	27. Mannar of Death 1	ation	of Injury oth, Dey Year)	28b. Tima Injury	of M	28c. Inju Wo 1 □	ry at ork? ]Yas 2□		28d. Describe	how injury occu	rred		
al or Attendi	al Director: After ted in by the funeral	3 Suicida 6 Could not be datarmined 28a. Place of Injury - At home, term, streat, tectory, office building, atc. (Specify) 28t. Location (Street e. City or Town, Stetle City or										ber or Rure	l Route	Number,
Ne Hospita T 24 hours	pletely fill	29a. Cartifiar 1 Certifying (Check only ane)	Physician: To the examiner: On tha b and man	best of my knows asis of axaminonar stated.	owledge, dee ation and/or i	th occurred nvastigetion	et tha ti	ima, data an opinion, dae	nd plece, o eth occurr	end due to the ed et the tima.	ceuse(s) and m data and place	enner es st , and dua to	ated.	use(s)
To th	To To To	29b. Signeture and title of certifiar  29c. Licansa number  D42518									29d. Data sign	ed (Month, i		
		30. Nama and addrass of person v					401	, Roci	kvill	Le, MD	20852			
	State	31. Data filed (Month, Dev, Year)		∌gistrar's Sign		- 1		,						

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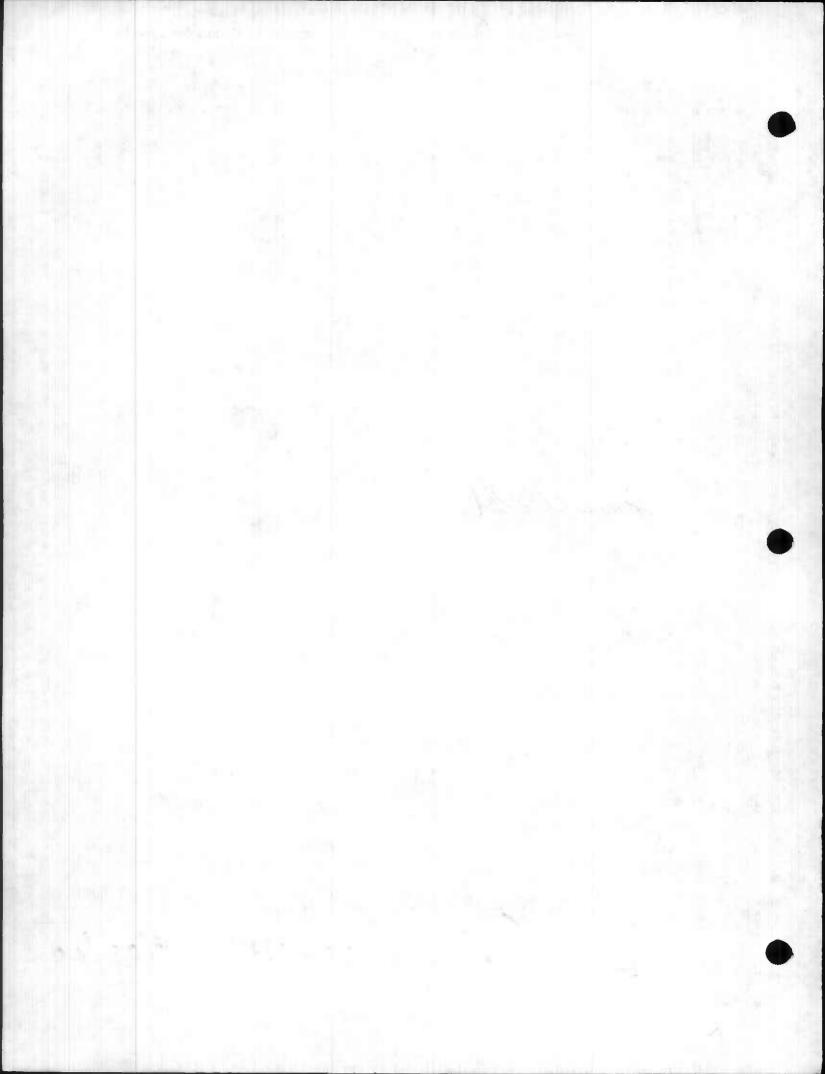


State of Maryland / Department of Health and Mental Hygiene 0 32836

							0.	Death			Reg. No.			
	_	1. Decedent's Name (First, Middle,	Last)					1		2. Date of Dea	ath	V-1-	3. Time of Deal	
Physician /Medical	_	NASSER		MEHDI	KHANI					Sept	. 26	2000	1644	
Examiner		4a. Fecility Name (If not institution,	give street and nun	nber)				4b. City, To	wn, or L	ocation of Deeth		nty of Death		
				SPITA		If Under 1		West		ister		rroll		
Funeral Director		215-76-6698 Usual Residence of Decedent	1 DKM 2 F	5 7	. last birthday) Yrs.		Days	Hours	Min.	8. Date of Birt (Month, Day 2-23-4		9. Birthp Coun Ira	elace (State or For htry) N	
show		10e. Stete 10b. County		10c. C	ity, Town or Lo							1	0d. Inside City Lir	
28a-f st notified	5 I	Maryland Car	roll		Syke	svill	.e						1⊠Yes 2□	
2 2 0		10e. Street and Number 354 ChiseledS	Stone Ro	a.		10f. Zip C		2178	4		10g. Citizen d		ntry?	
DV	2	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Dece Armed For 1 Yes If Yes, Give Year or Da	ces? 2 No		Was Deceder If Yes, specify 1 ☐ Yes 2		lispanic Ori an, Mexicer Specify:		ecify Yes or No- Rican, etc.)		ace - Americ lack, White,	etc.	
ygiene. ner than "natural", nt, the worder En, Completed by	2	15. Decedent's	and the second teacher all		16a. Dece	dent's Usual (	Occup	ation				Business/Inc		
o de	2	(Specify only highest ( Elementary/Secondary (0-12)	College (1-	-4or 5+)	life.	kind of work DO NOT use	retired	d)						
neigen in the	5		12		Prof	essor	0	f Ed	uca	tion	Edu	ucati	on	
d other event, Be Cc		17. Father's Name (First, Middle, La	,							e (First, Middle,	Maiden Sum	ame)		
marked matic ev		Ismail Mehi	khani					Kah	dije	eh Sad	dat			
9 m m		Ismail Mehikhani Kahd  9a. Informant's Name/Relationship (Type, Print)  Kobra Homayoun – Wife 354Chiseled Stone												
0 _ 5	2	20a. Method of Disposition  (**Disposition 3		State _	Place of Disponentery, cres	matory or other	er pled		met	Date 9-28-	20c. Location			
Department Important: It any Injury o		21. Signature Funeral Service Lic	ensee /	Mata	22	2. Name and	Addre	ss of Facilit	ty Un:	iversa	l II I	Mortu	ary In	
	carcai Evanillici	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								ia	unf	arc	tions	Corner
physicien and street the burdal-transit edical Examiner		Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events	art	Due to (	or as a consec	quence of):	ca	rd	ia	desc	arci	teon 2	tormen 22 yr	
g physicie es the bur ledical		Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events	art	Due to (	or as a consec	quence of):	ia	rd	ia	desc	arci	tion 2	Czyr	
g physicie es the bur		Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	c	Due to (d	or as a consec or as a conseq	quence of):						1	Corner 22 yr	
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igned by the ettending physicie be detached for use as the but by Physician/Medical	F	Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	c	Due to (d	or as a consec or as a conseq	quence of):				23b. Did t	obacco use o	24b. We	pebly 4 Unk	
has been signed by the ettending physicie pe 2 should be detached for use as the bur per per per per per per per per per pe	F	Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	c	Due to (d	or as a consec or as a conseq	quence of):				23b. Did t	obacco use o	24b. We ave cor	pebly 4 Unkere autopsy finding	
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entificate has been signed by the ettending physicle socior, page 2 should be detached for use as the burner of the page 2 should be detached for the page 2 should be physician/Medical Be Completed by Physician/Medical	F	Sequentially list conditions, if any, leading to Immediate couse. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Lest	c	Due to (d	or as a consector as a consequence of as a consequence of	quence of): quence of):	use giv	en in Part i	i.	23b. Did t 1 \( \text{1} \) 24a. Was a performance of the control	obacco use of the control of the con	24b. We ave cord of a	ere autopsy findir elleble prior to mpletion of cause death?	
this certificate has been signed by the ettending physicie al director, page 2 should be detached for use as the bure. To Be Completed by Physician/Medical	F	Sequentially list conditions, if any, leading to Immediate couse. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Lest  Pert II. Other elgnificant conditions  25. Was case referred to medical examiner?  1   Yes     No   No   No   No   No   No   No	d  contributing to dea  Hospital: 1 □ In   28a. Date of (Month)	Due to (contact to the partient 2.1	or as a consec or as a conseq	quence of):  quence of):  inderlying ceu	Oth	zen in Part i 26. Place er: 4 □ Nu	e of Deat	23b. Did t 1	obacco use o  /es 2 No  an autopsy med?  ies 2 No  ne) ence 6 □C	24b. We ave cor of a	ere autopsy findinaleleble prior to mpletion of cause death?	
this certificate has been signed by the ettending physicie al director, page 2 should be detached for use as the burner of the page 2 should be perceived by Physician/Medical	F	Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Lest  25. Was cese referred to medicel examiner? 1 Yes 2 No  27. Manner of Deeth 1 Netural 5 Pending	d	Due to (contract to the patient 2 the patien	PER/Outpatier 28b. Time of injury ome, farm, str	quence of):  quence of):  inderlying cau  int 3 DOA  if 28c	Oth	26. Place er: 4 Nu	e of Deat	23b. Did t 1 \( \)	obacco use of oscillation of the contract of t	24b. We ave cor of c	ere autopsy findin elleble prior to mpletion of cause death?	
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his certificate has been signed by the ettending physicial director, page 2 should be detached for use as the but To Be Completed by Physician/Medical	F 2	Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest  25. Was cese referred to medical examiner?  1 Yes 2 No  27. Manner of Deeth 1 Netural   5   Pending Investigat 3   Suicide   4   Homicide   1   Certifying F	Hospital: 1 In	Due to (continued to the patient 2 linjury on, Day Year)  of Injury - At high etc. (Special cost of my knows of examines of ex	or as a consequence or as	nt 3 DOA  f 28c M reet, factory, c	Oth C. Injury Wor  Office	26. Place er: 4 Nu yat k? Yes 2	e of Deatursing Ho	23b. Did t 1 \( \) 24a. Was a performance of Residual 28d. Describe h 28f. Location (S. City or Towned end due to the cred et the time, commended to the cred et the cred et the time, commended to the cred et the cre	obacco use of the control of the con	24b. We ave cor of a start of their (Specify urred manner as ste, and due to med (Month, I	pebly 4 Unk ere autopsy findin elleble prior to mpletion of cause death?  Yes 2 No  No  No  Route Number, atted, the ceuse(s)  Day, Year)	
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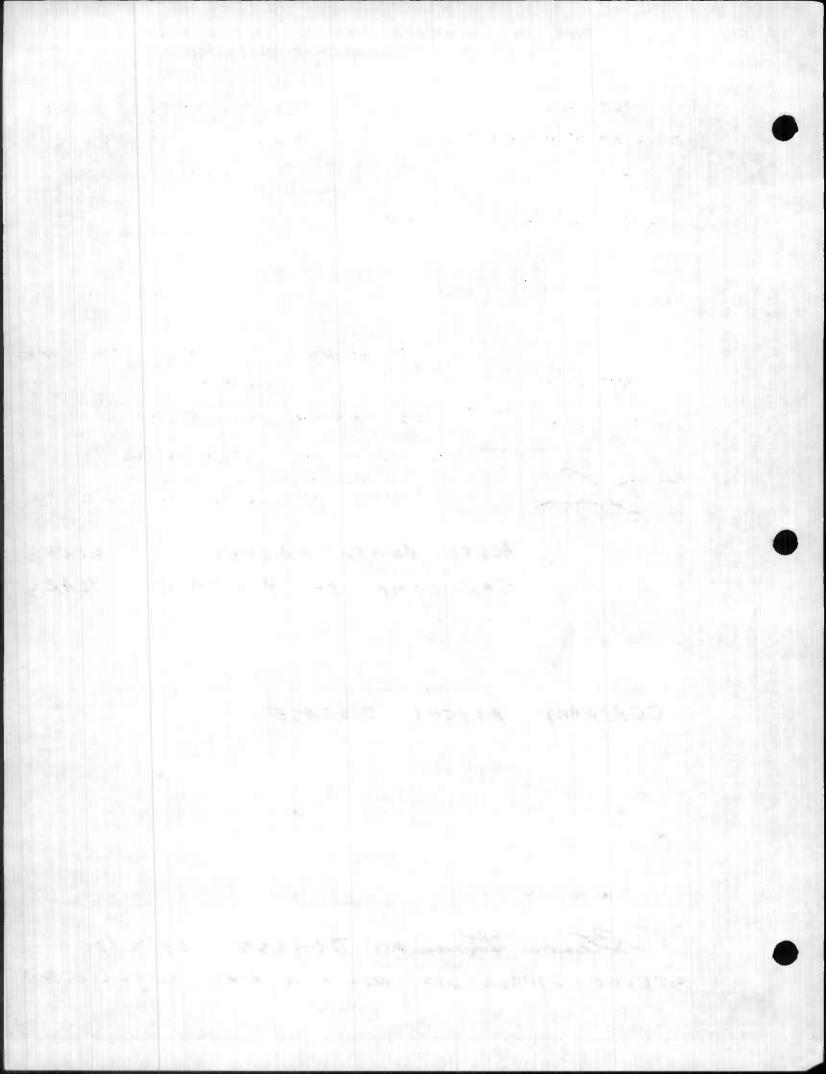


		State of Maryla		partment ertificate			nd M		jiene UU eg. No.	3	2837
	1. Decedent's Neme (First, Middle, Last)	)						2. Date of Dee	th	V	3. Time of Death
Physiciar /Medica	COLTUNE COTFOR	McKenna						Month Sept.	26, 200	Year	7:55 PM
Examine	de Freith, blome Minet institution sive	street and number)			1	4b. City, Tow	vn, or Loc	cation of Death	4c. County	of Death	
8 <b>H</b>	9307 Kendale Rd.						omac		Montg		
Funeral Director	216-44-9/59	7. Age (In yr 1 91	s. last birthde Yrs.	Months	Deys	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, April22	,1909	9. Birthi Coul Mar	olece (State or Foreign ofry) yland
and was	Usual Rasidence of Decedent  10a. Stata 10b. County	10c. (	City, Town or	Location							IOd. Inside City Limits
Mary	Maryland Montgom	erv	Pot	omac							1 X Yes 2 No
vith the Ma	10e. Sfreet and Number			10f. Zip (	Code	5-16	7	1	0g. Citizen of V	Vhet Cou	ntry?
th wit					208	354				USA	
72 hours after death with the Manyland naturel; or Neme 23a or 28a-f show after Examiner must be notified at the control of th	3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 No If Yes, Give Yeer or Detes:	U,S. 1	3. Was Decede if Yes, specif 1 ☐ Yes 2	_	lispenic Orlg an, Mexican, Specify:	pin? (Spe , Puerto f	city Yes or No- lican, etc.)		k, White,	can Indien, etc. ite
neturel',	15. Decedent's Educ (Specify only highest grade	cation e completed)	16a. De	cedent's Usuel ive kind of work a. DO NOT use	Occup done	ation during most	of working	00	16b. Kind of Bu		dustry
within ena.	Elamantary/Secondary (0-12)	College (1-4or 5+)	life						Own H	lome	
				Home 1	Make		da Nama	/First Middle	Ma <i>idan Sum</i> am	0)	
o tab								lodges	Waluari Surriani	9)	
	19a. Informant's Name/Relationship (Ty				r, City or Town,	Stata Zii	Code)				
tha tha	Richard Colton/Bro								ryland		
- HEE	20a. Method of Disposition		Placa of Dis	sposition (Namerematory or off	e of			Date	20c. Location -		
Pages int: # h	1  Burial 2  □ Cremation 3  □ R 4  □ Donation 5  □ Other (Specify)	temovel from State Ga		Heaven	rei piat	00)		pt.30,	Silver S	Sprin	g. MD
permit. Pages Department of Important: If the eny injury or o	21. Signeture of Funeral Service License		22. Name and	Addre	ss of Facility	DeV 222	ol Fune 2 Wisco	eral Hononsin Av	ne re.,	N.W.	
Physician /Medical	23a Party Enter the disease, or compliance, or heert failure. List only or Immediate Ceuse (Final disease or condition	icetions that caused the de ne ceuse on each line. Cerebral					cardiac o	r respiratory err	rest,		Approximate Interval Between Onset and Deeth 5 months
Examiner	rasulting in death)	ð	(or es e con	sequence of):				ē Çu	111		
be axecuted sician and burial-transit	Sequentially list conditions,	Due to	(or es a con	sequence of):							
		Right Hem	iplagi	La						1	
at the death certificate be 1 by the attending physicia etached for use as the bur	thet initieted events	Due to	(or es e cons	sequence of):		W.					
d for	Part II. Other significant conditions con	ptributing to death but not r	esulting in the	e underlying ca	use aiv	ren in Pert I	-	23h. Did to	obacco use co	ntribute 1	o the cause of death
that that det det		initioning to obtain but not in	osuling in the	o underlying ca	use giv	on are enti-			′es 2⊠No		bably 4 Unknow
been should				1				24e. Was a perfor		87	/ara autopsy findings vailable prior to empletion of cause death?
The law ate has page 2								10Y	es 2 No	1	☐ Yes 2☐ No
cartificate rector, page	25. Wes cese referred to medical					26. Place	of Death	(Check only or	na)		
2 00	1 Yas 2 No	dospitel: 1 Inpatient 2 28a. Dete of Injury (Month, Day Year)	ER/Outpa 28b. Time Injur	e of   28	A Oth	4 LI NU	-		ence 6 Oth ow Injury occur		ity)
Attending or death.  Sctor: After by the fune	2 Accident investigation	No									
al or Attended as after death	27. Manner of Deeth 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 4 Homicide 28a. Dete of Injury (Month, Day Year) 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury M 28b. Time of Injury of Injury of Injury of Injury M 28b. Time of Injury										ai Route Number,
Hospi 14 hour Funer (taly fill	29a. Certifier 1 Certifying Physical Check only 2 Medical Examinations	nclan: To the best of my k ner: On the basis of exami and inner steted.	nowledge, de netion end/or	Investigation,	in my c	oplnion, deat	d place, a th occurre	and due to tha ded at the time, o	ause(s) and ma date end placa,	anner as and due	stated. to the cause(s)
To the within 2 Comple	E 29b. Signiture and the d conflor	Ata	de	29c.	Licens	se number	94	8	29d. Dete signe	d (Month	Day Year)
	J. Blaine I	1987 39			con	sin A	ve.	Bethesd	a, MD 2	0814	
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State of Maryland / Department of Health and Mental Hygiene 00 32838

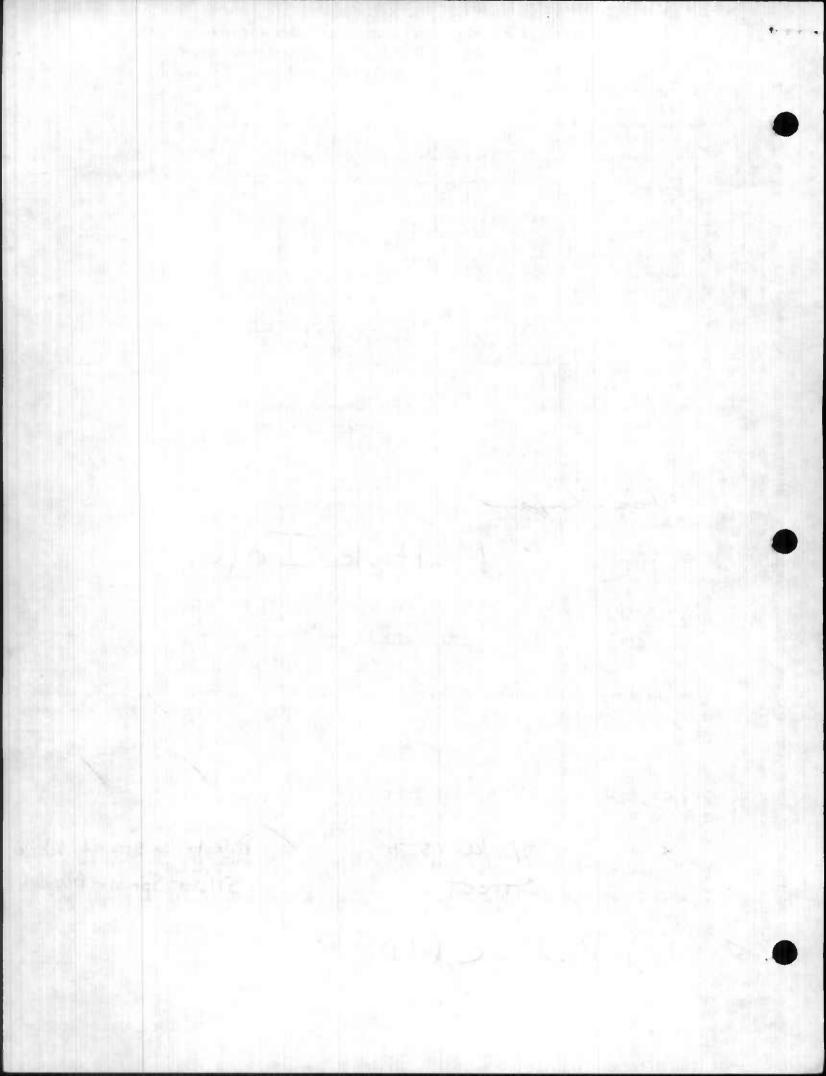
				Cei	rtificate d	of Death	7		Reg. No.		
	1. Decedant's Nama (First, Mic	idla, Last)		1000				2. Data of D	eath Day	Yaar	3. Time of Death
Physician /Madiso	Pani	Marks						Septemb			1:20am
/Medica Examine	An Carilla Mana /// nat landbu	tion, giva street and	num <i>ber)</i>			4b. City, T	own, or L	ocation of Daa	-		
	Hebrew Home o	f Greater	Washingt	on		Ro	ckvi	11e	Mon	tgome	ry
Funeral	5. Social Security Number	6. Sax	7. Aga (In yrs. las	st birthday)	If Undar 1 Ya	-	r 24 Hrs. Min.	8. Data of Bi (Month, D	rth	9. Birthp	placa (Stata or Foraign
Director	085-14-2082	1 ØM 2□ I	87	Yrs.	NOTION	lys Flours	IVIII I.	March	7, 1913	New	York
P	Usual Rasidanca of Dacedant										
aryler and a supplemental and a	10a. Stata 10b. Cour	nty	10с. Слу,	Town or Lo	cation					1	0d. Insida City Limits 1 □XYas 2 □ No
M P	Maryland Mo	ntgomery	Ro	ckvil:	le						ILATES ZLINO
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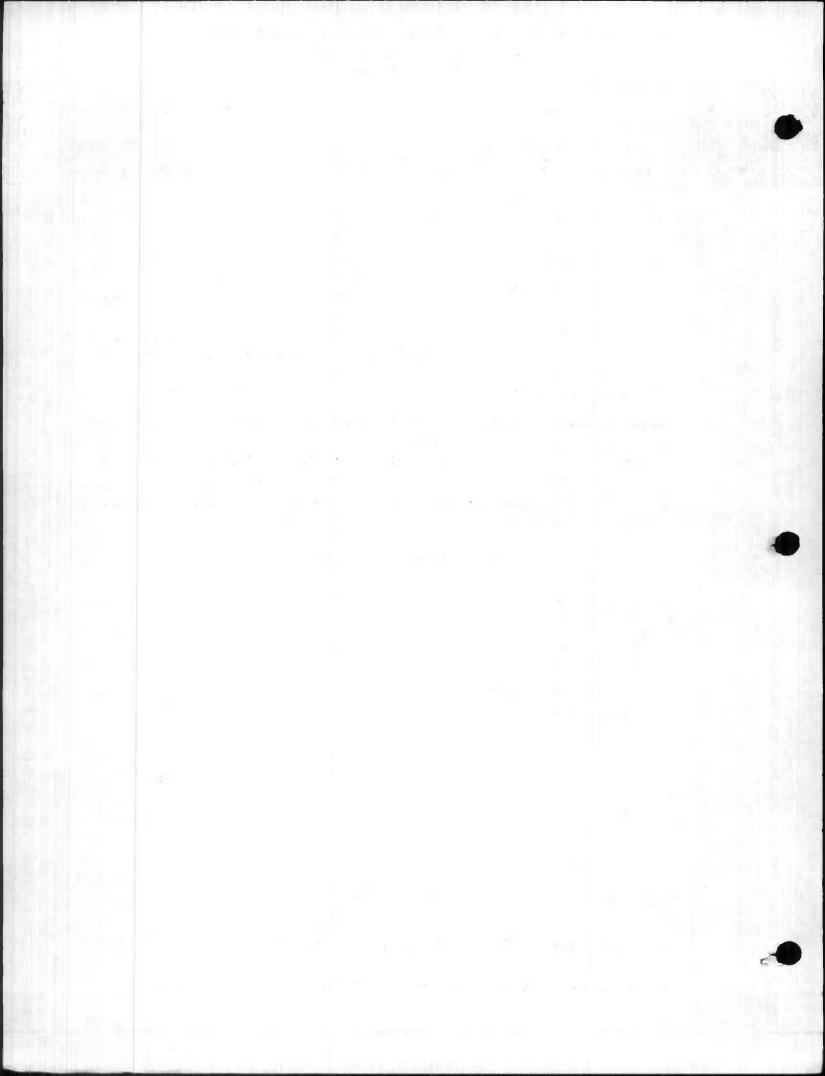
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Moo  20e. Method of Disposition  XXBurial 2 Cremetion  4 Donation 5 Other (Sp  21. Signeture of Funeral Service is  23a. Part Earty The diseese, or shock, or heart failure. List of the cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death)  Part II. Other significant condition  DM II  HTN  25. Was case referred to medical examiner?  1 Yes 2N No  27. Manner of Deeth 28. Natural cause (Diseese or Injury thet initieted events resulting In death) Last  DM II  HTN  25. Was case referred to medical examiner?  1 Yes 2N No  27. Manner of Deeth 28. Natural cause (Diseese or Injury thet initieted events resulting In death) Last  29. Accident Notation of Could in determine the individed of Could in determine the could be could be could in determine the could be could in determine the could be could	4a. Fecility Neme (If not institution, give street end number  Cherry Lane Nursing Hom  5. Social Security Number 212-20-1558  Usual Residence of Decedent  10a. Stele 10b. County MD Howard  10e. Street and Number 9229 Grant Avenue  11. Merital Status 1 Never Married 2 Married 3XWidowed 4 Divorced  (Specify only highest grade completed)  Elementery/Secondary (0-12) 12  17. Father's Name (First, Middle, Last)  Raymond Dewey Moore  19a. Informant's Name/Relationship (Type, Print)  Raymond N. Moore, Jr./Son  20e. Method of Disposition XYBurial 2 Cremetion 3 Removal from Status 4 Donation 5 Other (Specify)  21. Signeture of Funeral Service focuse  23a. Part Ener the disease, or complications thei cause shock, or heart failure. List only one cause on each immediate Cause (Finel disease or conditions, fany, leading to immediate cause Enter underlying the initiated events resulting in death) Last  Part II. Other eignificant conditions contributing to death  DM II  HTN  25. Was case referred to medical examiner?  1   Yes   20   No  27. Manner of Deeth 1   20   20   20   20   20   20   20   2	Raymond N. Moore  4a. Fecility Neme (If not institution, give street end number)  Cherry Lane Nursing Home  5. Social Security Number  212-20-1558  Usual Residence of Decedent  10a. Stale  10b. County  MD  Howard  10c. City  MD  Howard  10c. City  MD  Howard  11. Merital Status  1 Never Married  3 XWidowed 4 Divorced  (Specify only highest grede completed)  Elementen/Secondary (0-12)  12. College (1-4or 5+)  13. Decedent's Education  (Specify only highest grede completed)  Elementen/Secondary (0-12)  17. Father's Name (First, Middle, Last)  Raymond N. Moore, Jr./Son  20e. Method of Disposition  XXBurial 2 Cremelion 3 Removal from State  4 Donation 5 Other (Specify)  21. Signeture of Funeral Service Foodings  And College (1-4or 5+)  22. Signeture of Funeral Service Foodings  And College (1-4or 5+)  Due to (or beart failure. List only one cause on each line.  Immediate Cause (Finel disease or conflicions that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Finel disease or conflicions that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Finel disease or conflicions in the caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Finel disease or conflicions in the caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Finel disease)  DM II  HTN  25. Was case referred to medical examiner?  1 Yes 2 Xe No  27. Manner or Deeth	1. Decedent's Name (First, Middle, Last)   Raymond N. Moore	Raymond N. Moore  4a. Fecility Neme (If not institution, give street and number)  Cherry Lane Nurssing Home  S. Social Security Number  212—20—1558  Usual Residence of Decedent  10a. State  10b. County  MD  Howard  10c. City, Town or Location  Howard  10c. City, Town or Location  Laurel  10c. City, Town or Location  Laurel  10c. Street and Number  9229 Grant Avenue  11. Merital Status  1   Never Married   2   Married  31. Was Decedent Ever in U.S.  13. Was Decedent If Yes, Specilion  14. Specily only highest grade completed)  Elementery/Secondary (0-12)  15. Decedent's Education  (Specily only highest grade completed)  Elementery/Secondary (0-12)  12. Was Decedent Ever in U.S.  13. Wes Decedent If Yes, Specilion  14. Specily only highest grade completed)  15. Decedent's Education  (Specily only highest grade completed)  Elementery/Secondary (0-12)  17. Father's Name (First, Middle, Last)  Raymond Dewey Moore  19a. Informant's Name/Relationship (Type, Print)  Raymond N. Moore, Jr./Son  20e. Method of Disposition  Avgured 1   Content of Specily)  21. Signetured Funeral Service Yeesee  22. Name and 1  23a. Path. Lawf he disease, or completelions their caused the death. Do not enter the mode of Shock, or heart failure. List only one cause on each line.  22. Name and 1  23a. Path. Lawf he disease, or completelions their caused the death. Do not enter the mode of Shock, or heart failure. List only one cause on each line.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. City Index of Decedent Shock or heart failure. List only one cause on each line.  22. Name of Decedent Shock or heart failure. List only one cause on each line.  Sequentially list conditions in any leading of the Underlying Cause. Enter Underlying Caus	Raymond N. Moore   As. Fecility Neme (*Irrost institution, give street end number)   As. Fecility Neme (*Irrost institution, give street end number)   As. Fecility Neme (*Irrost institution, give street end number)   As. Fecility Neme (*Irrost institution, give street end number)   As. Fecility Neme (*Irrost institution, give street end number)   As. Fecility Neme (*Irrost institution, give street end number)   As. Fecility Neme (*Irrost institution)   As. Fecility Neme (*Irrost instit	Raymond N. Moore  4a. 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Decoderin's Name (First, Middle, Last)  Raymond N. Moore 4s. Facility Name (if in statution, pive street and number)  Cherry Lane Nursing Home Social Security Number  Cherry Lane Nursing Home  Cherry Lane Nursing Home  Social Security Number  Cherry Lane Nursing Home  10. Sets  10. Cherry Mark 2   4. Chey 1 fam. 1 for 1	1. Decedent's Name (Frex. MicSte, Laet) 44. Feelity, Neme (if not intritution, pive street end number) Cherry Lane Nursing Home Cherry Lane Laure La		

DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3284 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Dey Month Year Jerome A. Mullett 6, October 2000 3:45 pm 4a. Facility Nama (If not institution, give streat end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 8118 Forest Hill Drive Ellicott City Howard If Under 1 Yaar Months Days If Under 24 Hrs. Hours Min. 5. Social Sacurity Number 7. Aga (In yrs. lest birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) Days 1XM 2□ F Yrs. 70 370-28-8115 Oct. 5, 1930 Michigan Usual Rasidance of Dacedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 ☑ No Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 8118 Forest Hill Drive 21043 United States 14. Race - American Indien, Bleck, Whita, etc. 12. Was Decedant Evar in IJ,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuben, Maxican, Puerto Rican, atc.) 1 Navar Marriad 2 Married ☐ Yas 20 No f Yas, Giva 1 ☐ Yas 2 € No Specify: Specify: white 3 Widowed 4 □ Divorced Year or Datas: 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada completed) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) Asst. General President I.U.E.C. 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nema (First, Middla, Maidan Sumama) Michael E. Mullett Josephine Foltz 19a. Informant's Name/Ralationship (Typa, Print) 19b. Malling Addrass (Street and Numbar or Rural Routa Number, City or Town, State, Zip Code) Dan Mullett / son 826 Fairfield Ave. Westminster, MD. 20b. Placa of Disposition (Name of 20a, Mathod of Disposition Oct. Data 10 20c. Location - City or Town, Stata metery, crametory or othar place) 1 ☐ Burial 2 🖾 Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Metro Crematory 2000 Catonsville, Maryland 21. Signatura of Funaral Sarvice Licensee 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 18010A 4112 Old Columbia Pike Ellicott City, MD. 21043 23a. Part1. Enter the disaesa, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximeta Intarval Batween Onset and Death Immediata Ceuse (Final of Unknown Orisin metastatio 16 months · Adenocarcinina disaasa or condition rasulting in death) Dua to (or es a consequenca of) to bine printeneum Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Diseesa or injury that initieted events rasulting in daath) Last Dua to (or es e consequança of) Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably Unknown 216 Bugintin to belows 24b. Were eutopsy findings evellabla prior to complation of causa of death? 24e. Was an autopsy performed? COPD 1 ☐ Yas 20No 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical 26. Placa of Death (Check only one) examinar? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 27. Manner of Death 28a. Dete of Injury (Month, Day Yaar) 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? 1 Natural 5 Panding

Box 68760. 8 8 Records, P.O. certificate S I

Examiner Physician/Medical þ Completed Be Atter

**Physician** 

/Medical

**Examiner** 

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Funeral

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**Funeral** 

Director

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item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examinar must be notified at

Hygiene.

. Peges 1 and 2 should be fit ment of Health and Mental H sant: If item 27 is marked off jury or other traumatic even

permit. Pege Department of Important: If any Injury or odce.

**Physician** /Medical

Examiner

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filed within 72 hours efter

21215-0020

Baltimore, Maryland

Certification: To after death Director:

2 Accidant

4 Homicide

(Check only one)

29b. Signatura and titla of certifiar

31. Data filad (Month, Day, Year) 2000

3 Suicida

29a. Cartifiar

30. Nama and

Jan

invastigation

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Division of Vital 8

24 hours Funeral

Within 2 To the i

State Registrar

Medical

address of person who completed causa of death (Itam 23a) (Type, Print) K. Mr. Find OHO 32. Registrer's Signatura

MD

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

11065

🕮 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, data and piece, end due to tha causa(s) and mannar as stated.

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end flannar stated.

29c. Licansa number

030573

29d. Date signed (Month, Day, Year)

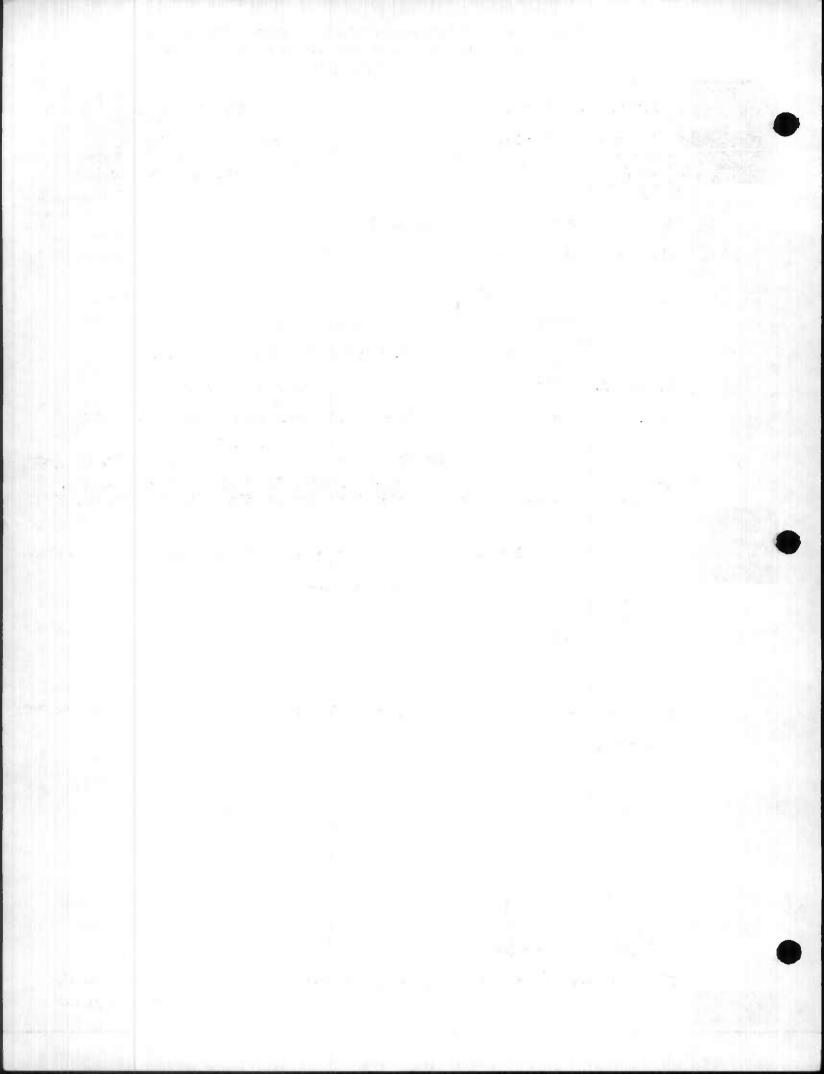
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

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Little Patuxent Parkuny, Columbic

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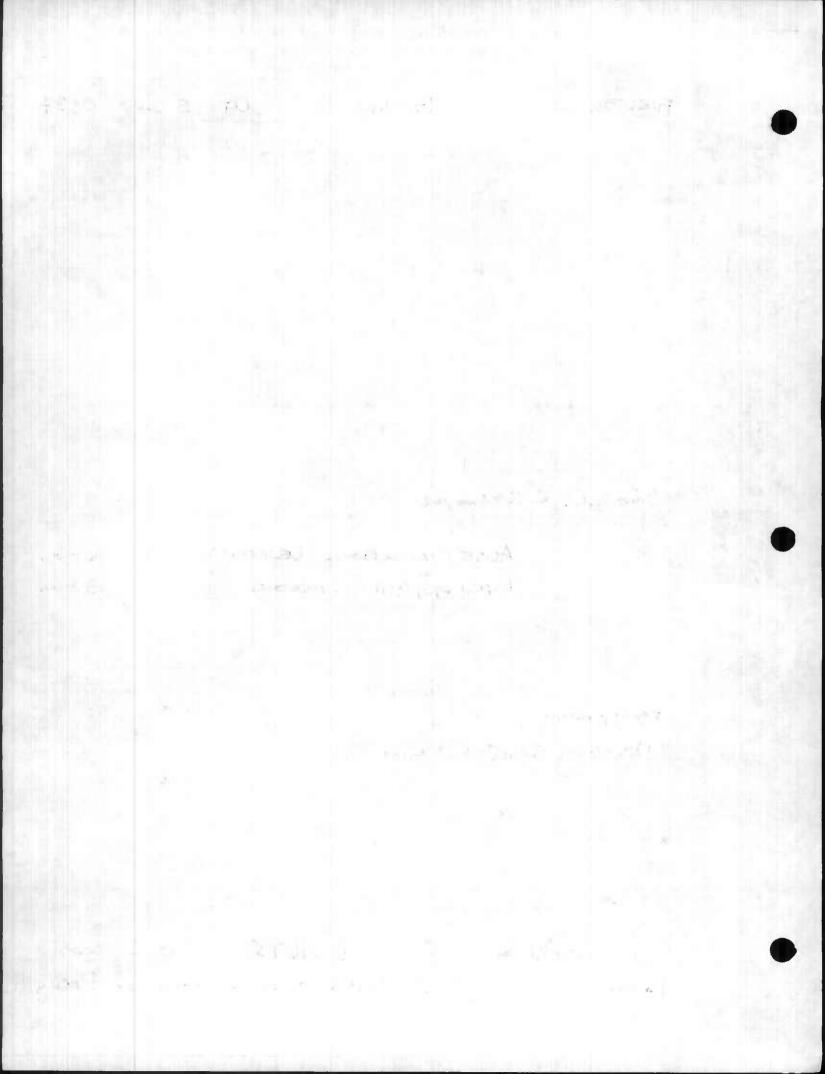
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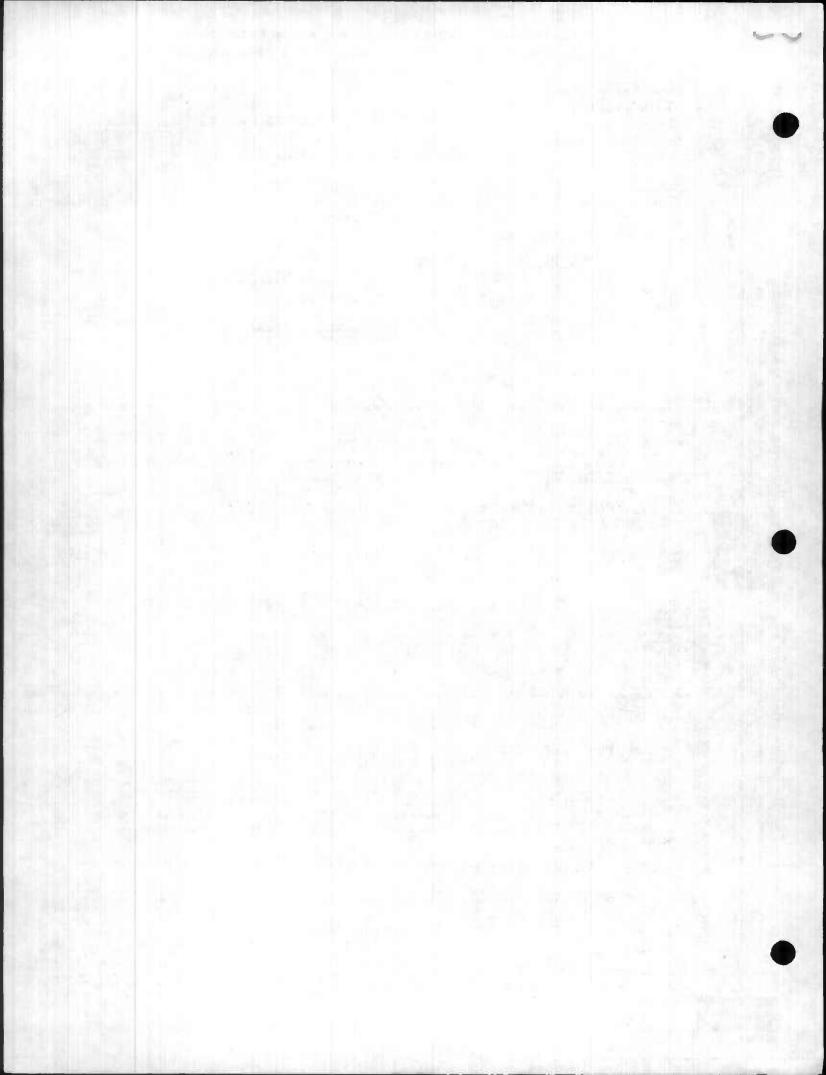
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Funeral	5. Social Security Number	6. S	ax □√M 2□ F	7. Age (In yrs		Months	Days	Hours	Min.	8. Date of Birt (Month, Da	h y, Year)	9. Birt	thplace ( buntry)	State or Forei
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			C	ertificat	e of	Death		Reg. No			
	1. Decedent's Neme (First, Middle, Las						2. Date of		v Vas	3. Time of Do	eath
Physician /Medical	TINGSUAN	NI					Septer	tember 30 2000 8:05 P.M.			.M.
Examiner	4e Facility Name (II not institution, give Holy Cross Hospi						m, or Location of D Spring	eath 4c.	County of Dontgome	eath Ery	
Funeral Director	5. Social Security Number 6. S 212-21-6881	ex 7. Age ( ✓ M 2□F	In yrs. last birtho	Months	1 Yeer Days	If Under 2 Hours	Min. 8. Dete of Month.	Birth Day, Year) 16, 19	9.1	Birthplece (State or F Country) China	
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mit. Pages 1 an partment of Heal portant: if them 2 y Injury or other SS.	20e. Method of Disposition  1									or Town, State	yland
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this ral di	1 Yes 25 No  27. Margner of Death 1 Ablatural 5 Pending	Hospitel: The Inpatient 28a. Date of Injury (Month, Dev		ne of	28c. Inju	iry at ork?		Residence ribe how Inju		Specify)	
or Att	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	9 00- 51	y - At home, farm (Specify)	, street, facto		Yes 2 h	28f. Locati	ion (Street a r Town, Stat		r Rurai Route Numbe	er,
To the Hospital or All within 24 hours after of All within 24 hours after or to the Funeral Direct completely filled in by Medical Certifi		ysician: To the best of niner: On the basis of e and manner state	xemination and/o								
Vithin To the comple	29b. Signature and title of certifier					se number					
10	Jass.				D	286	56	29d. Date signed (Month, Dey, Year) OCTOBER, 1, 2000  ER SPRING, MD 209/0			00
ı	30. Name and advess of person who RAVI VASSI, NUD,	completed ceuse of dea	cend A	rpe, Print) SENUE	#	4048	3, SILVE	er St	PRING,	MD 2091	0
State Registrar	31. Date filed (Month, Day, Year) OCT 0 6 20	32. Begistrar	s Signature	do	sek.		SATT.				



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month, Day Yeer September 30, 2000 **Physician** JOHN ANTHONY NUCENT 623 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street end number) **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 128-22-7838 Yrs. 74 Director April 30,1926 New York Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits t TYes 2 □ No Florida Broward Deerfield Beach Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 2059 Southwest 15th St., #225 33442 USA Herne 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Meritel Status 1 N Yes 2 No Navy If Yas, Give Year or Dates: TATES T.T. 1 ☐ Never Married 2 Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: White by 3 Widowed 4 Divorced II\_WW 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Attorney Law 12 18. Mother's Name (First, Middla, Maiden Sumame) 17. Father's Neme (First, Middle, Last) merked o Pages 1 and 2 should be Francis Mary Huschle Daniel Nugent Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2059 Southwest 15th St., #225, Deerfield Beach, Teresa E. Nugent/Wife hepartment of Health mportant: If Item 27 20c. Location - City or Town, State 20b. Ptace of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removei from State 10/4/00 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Holloway Funeral Home Professional Association 21. Signature el Funerai Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** immediate Cause (Final disease or condition rasulting in daath) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner maestice Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initieted events Due to (or as a consequence of): CADZ thet initieted events resulting in death) Last Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings evaileble prior to complation of cause of death? Be Completed 24e. Was an autopsy page 2 should performed' 1 Yes 25 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physiolan: within 24 hours after death.

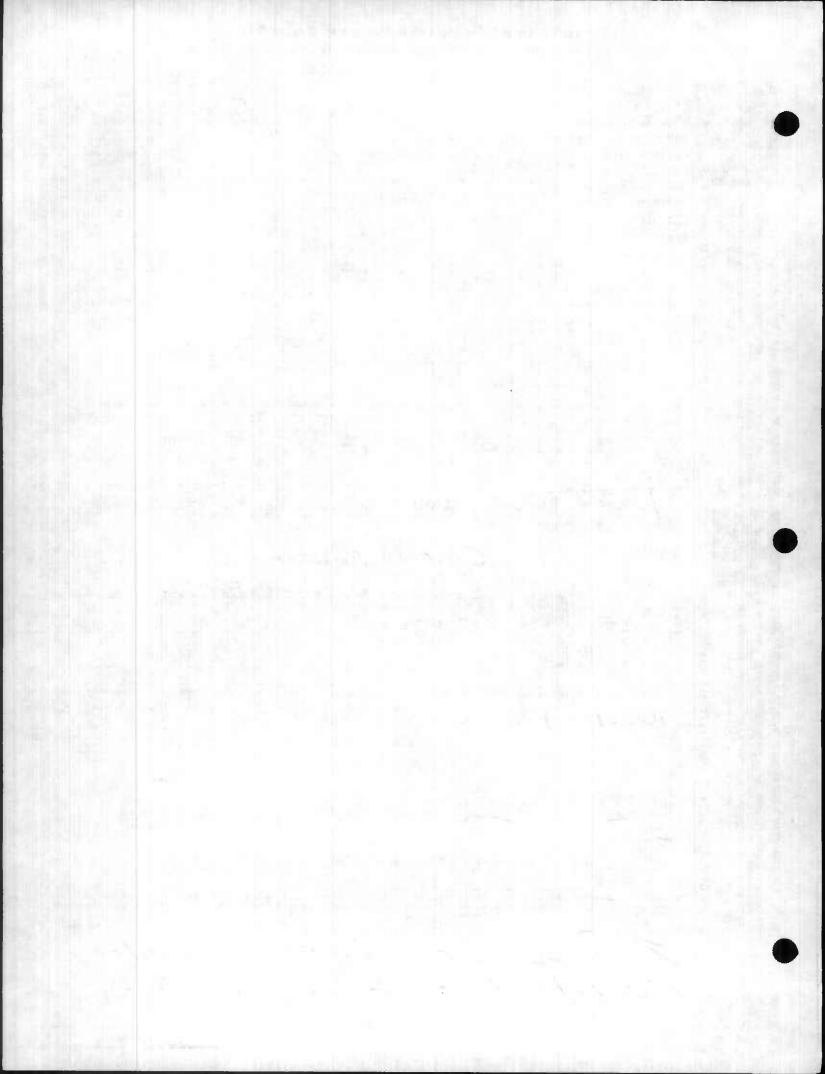
To the Funeral Director: After this certifice completely filled in by the funeral director, p. 25. Was case referred to medical 26. Place of Death (Chack only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To ↑ Unpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding investigation Naturat 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide \*\*Cortifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier (Check only one) 29b. Signeture and title of sorullar 29c. License number 29d. Date signed (Month, Day, Year) 10 mg 30. Neme and address of person who completed cause of death (flem 23a) (Type, Print) 32.

DHMH 16 Rev 6/95

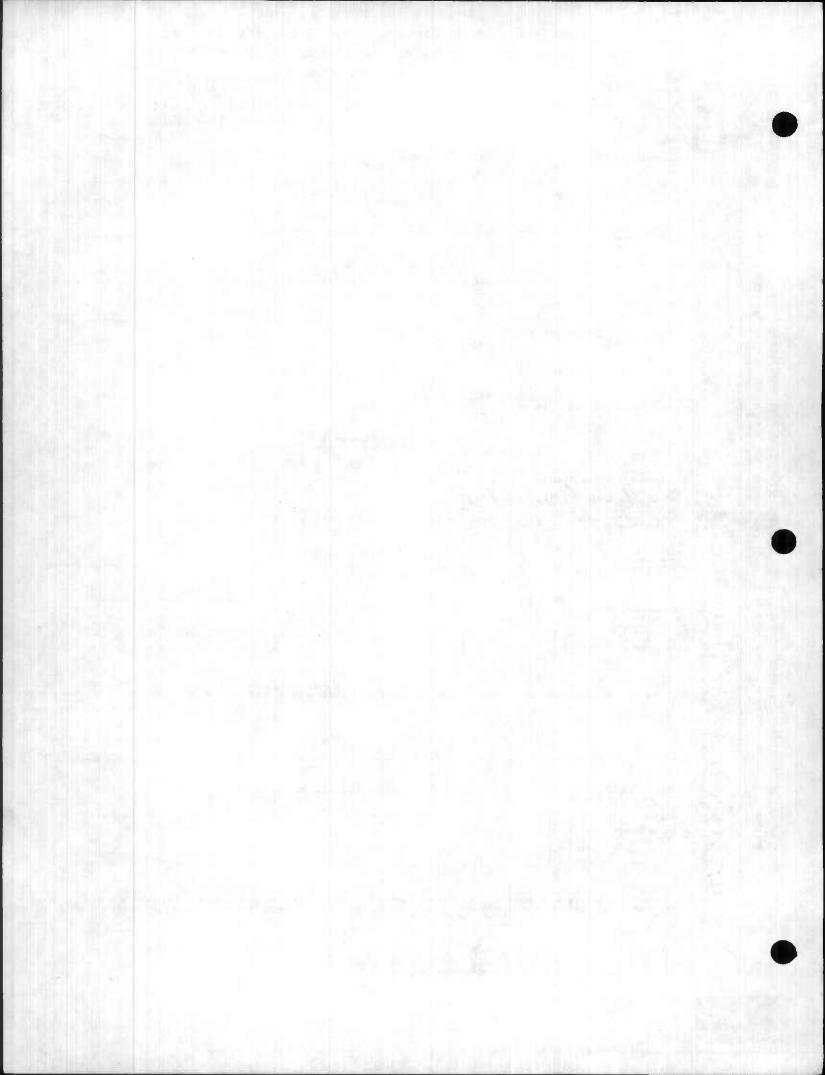
Registrar

2000



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32845

				Cei	rtificate	of Death	R	eg. No.			
	Physician	1. Decedent's Neme (First, Middle, Last)	E	411			2. Date of Deat Month	h Dey Yeer	3. Time of Deeth		
	/Medical	000				4h City Town	or Location of Death	4c. County of Deet			
	Examiner	48 Facility Name (If not Institution, give s SUBULBN NO SATAL				BELLAG	hod	m autoc	MERY		
	Funeral Director	5. Social Security Number 6. Sex 1 X 1 X 1 X 1 X 1 X 1 X 1 X 1 X 1 X 1	M 2□ F 7. Age (In yrs	· last birthdey) Yrs.	Months D		Min. (Month, Day,	9. Birt Co , 1970 Gua	hplace (State or Foreign nuntry) temala		
	/land	10a. Stete 10b. County		10d. Inside City Limits							
	a-far offer ctor	Maryland Montgomer	y Sil	ver Sp	ring				1 ☐ Yes 2 No		
	or 28a-f s be northed	10e. Street and Number			10f. Zip Co	de	1	0g. Citizen of What Co	ountry?		
	a 23a	2422 Ross Road, Ap		10	20910			Guatemala	rican Indian		
050	within 72 hours effer deeth with the Maryland ene. than "natural", or items 23e or 28e-f show its Wedest Essenther must be notified at ampleted by Funeral Director	11. Meritel Stetus  1 XNever Merried 2 Merried 3 Widowed 4 Divorced	2. Wes Decedent Ever in t Armed Forces? 1 ☐ Yes 2 ②NO If Yes, Give Yeer or Detes:		was Decedent If Yes, specify 1 ☑ Yes 2 □	No Specify:	? (Specify Yes or No- querto Rican, etc.)	Specify:			
9-0	"natural", or	15. Decedent's Educ	ation	16a. Dece	dent's Usuel O	ecupation		16b. Kind of Business/	White Industry		
21215-0020	ed within 72 hox ygiene. or than "natura ft, the Completed	(Specify only highest grade Elementery/Secondery (0-12)	College (1-4or 5+)			lone during most of etired)	working	01			
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ary	2 should and M is mar is mar in a summat	19a. Informant's Neme/Reletionship (Type	oe, Print)	19b. Maili	ng Address (S		or Rural Route Number	, City or Town, State, 2	Zip Code)		
	1 and 2 Health a em 27 is	Bayron Ovalle / Br		2422	Ross F	Road, Apt	102, Silv				
Baltimore	Peges nent of int: If It iry or o	20e. Method of Disposition  1 🕅 Buriel 2 Cremetion 3 Recommendation 5 Other (Specify)	emover from Stete		osition (Name of matory or other io Gene			20c.Location - City or De La Villa Guatemala	Town, Stete a De Salcaja		
Balt	permit. Peg Department Important: I any injury o	21. Signeture of Funeral Service License	Daley -	F	rancis		ns Funeral		ng, MD 20901		
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	/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	Herour								
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	tificate be executed as the burial-transit O       AM   Addical Examiner	Sequentially list conditions, if env. leading to immediate	CHOWIC A	(or es e conse	quenca of):	18/					
68760,	sicien sicien	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events			M M						
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ital	s certificate he director, page	25. Wes case referred to medical examiner?				26. Plece of	Deeth (Check only or	18)			
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Ö	pital or A burs after eral Direction of the control	4   Hornicide	building, etc. (Spec	ary)			Ony of You	ri, Statey			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director, OV ALL MAR Redical Certification: To Be Wedical Certification: To Be										
	Within To the Comp	29b. Signeture and title of certifier	[0.45]		9d. Date signed (Mon						
		) un	015236	236 SEPTEMBER 14, 2000 Exviver Pike , DOCKVILLE, MO 2085L							
	5	30. Nema and address of person who con	com the Co	om 23e) (Type,	Print)	-ockville	Pites, Oc	xxivius, W	10 20852		
1	State Registrar	31. Dete filed (Month, Day, Year) OCT 0 2 200	32. Registrer's Sign	neture A	doo	V	•				



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32846 State of Maryland / Department of Health and Mental Hygiene Certificate of Death

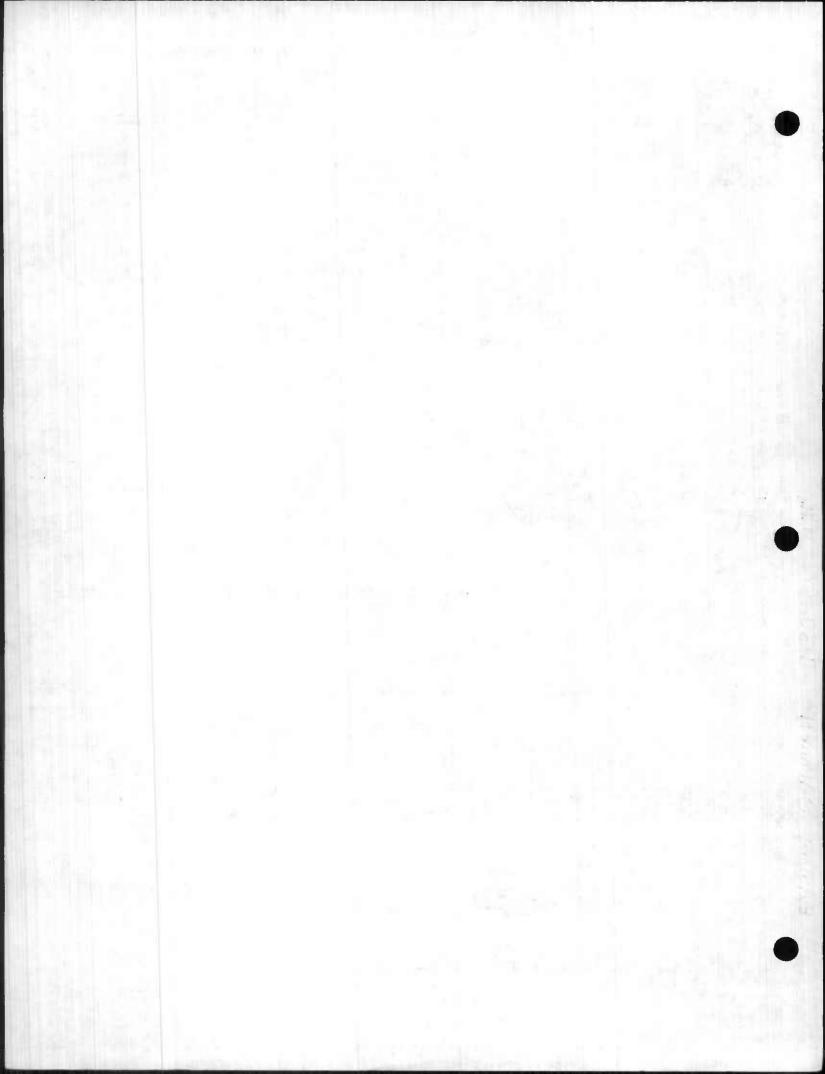
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9.30-00

Edward Udonnell

1	Physician /Medical	Edward J. U I					th City To	un orla	Month Sept.	30,2000	Year	11:40 AM		
	Examiner	Suburban Hospi		7. Age (In yrs.	last hirthday	a) If Under	I	Bethe	sda,	Md.	Montg	omery	7	
	Funeral Director	179–12–9876 Usual Residence of Decedent	M 20 F	7. Age (in yrs.	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Feb 9,			place (Stata or Foreigntry) PA.	
	ter death with the Maryland theme 23e or 28e-f show the mast be modified at the mast Director	10e. Stete 10b. County	nery		ity, Town or L	ocation							10d. Inside City Limits	
	3a or 28a-f a st be notified		rive			10f. Zip 208.					10g. Citizan of U.S.A.	What Cou	ntry?	
020	alf. or	3 ☑ Widowed 4 ☑ Divorced	Armed F	2 No	, my		dent of Hispanic Orlgin? (Spec cify Cuban, Maxican, Puerto R 2 No <i>Specify:</i> X			ecify Yes or No Ricen, etc.)	city Yes or No- Ricen, etc.) 14. Rac Blac Specify		e - American Indian, ck, White, etc.	
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Balt	Oppartment Important: I any injury o	21. Signature of Funeral Service L	treveld	1		171 1	V. M.	[aple	Aver	nue-Vie	nna, Vi		Home, Inc. a 22180	
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the d within 24 hours share death.  To the Funeral Director: After this certificate has been signed by the completaly filled in by the funeral director, page 2 should be detached Medical Certification: To Be Completed by Physis										an autopsy ormed?	a	Vere autopsy findings vailable prior to ompletion of cause I death?	
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>	Physician: this certific and director. TO Be (	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	] ER/Outpatio	ent 3 DO	A Oth	or:			idence 6 🗆 Ot	her (Speci	ify)	
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	To the Hospital within 24 hours a To the Funeral I completely filled Medical Ce		Physician: To the kaminer: On the band man											
	To the complete of the complet	29b. Signature end title of certifier	m		29c. License number					29d. Date sign				
		30. Name and address of person w	no complated ceu	sa of death (ite	m 23a) (Type	Print)	4.	Rock	ille	, man	dend a	0851		
	State Registrar	31. Data filed (Month, Day, Year) OCT 0 2	2000 32. 1	Registrar's Sign		boo	uds							

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** WILLIAM PAETOW 1243 10 2000 /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ATLANTIC GENERAL HOSPITAL BERLIN If Under 24 Hrs. WORCESTER If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Min 10 M 20 F Deys Hours 85 Yrs. 094-03-8087 Director Usuef Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits NY ULSTER HIGH FALLS 1 Ayes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 328 Mossy Brook RD. 12440 U.S.A. Funeral 14. Rece - American Indien, Bleck, Whife, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merital Sfetus 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PIANO TUNER MUSIC 12 Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ahould be ind Mental I AUGUST PAETOW LIDDY CLEMENS 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 328 Mossy Brook Rd. High Falls NY 12440 ARLENE PAETOW artment of Health ortant: If Nem 27 Saltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Sfete 20a. Method of Disposition Dete 1 ☐ Burial 2- Cremetion 3 ☐ Removel from Stete 10 - 4SALISBURY, MD. 4 ☐ Donetion 5 ☐ Other (Specify) SALISBURY CREMATORY 22. Name end Address of Fecility ULLRICH FUNERAL HOME BERLIN, MD. 21811 23e. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Aprile Procondia Examiner Physician/Medical Examine Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events that initieted events resulting in death) Last Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, þ 24b. Were autopsy findings evaileble prior to completion of cause of deeth? Be Completed 24e. Wes an autopsy performed? 1 ☐ Yes 1 Yes 2 No 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 Medical Certification: To 27. Menner of Death 28c. Injury et Work? 28d. Describe how Injury occurred Division or Attending 5 Pending investigation 1 BNaturel death. 1 Yes 2 No 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end menner stated. 29a Certifier 29b. Signature 29d. Date signed (Month, Dev. Year) person who completed cause of death (Item 23a) (Type, Print) Ether

Registrar

31. Defe filed (Month, Dey, Year)

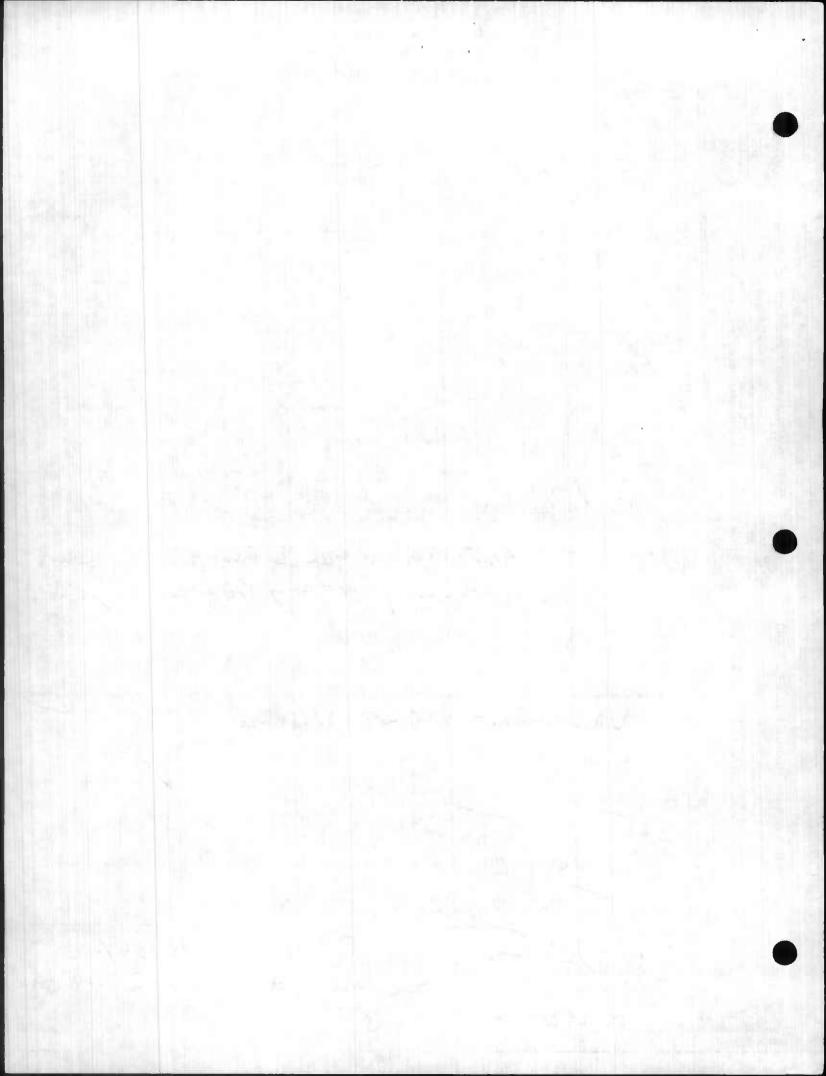
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etow, William

32. Registrer's Signature



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State of Maryland / Department of Health and Mental Hygiene

			Cei	rtificate o	Death		Reg.	No.	1 32	848	
Decedent's Name (First, Middle						Mo	te of Death	Day	Yeer	Time of Death	
Melvin Leona						1.00	BER	and		:13 A.m	
4a Facility Name (If not institution	The state of the s		- 0		4b. City, Town,		of Death	4c. County		2	
FRANKLIN SQUAR				W11-4-4V	KOSEZ				ALTIMOR		
5. Social Security Number 212-03-8439	6. Sex_ 7.	Age (In yıs. les	t birthday) Yrs.	Months Day		Vin. (Mo	te of Birth onth, Day, You USt 3, 1	1914	9. Birthplace Country) Virgin	(Stete or Forei	
Usual Residence of Decedent		10c. City, 7	Tour or Lo	ontion					104	Inside City Limit	
10a. State 10b. County	•									1 ☐ Yes 2 🔯 N	
	imore	Dé	altim								
10e. Street and Number				10f. Zip Code					What Country?		
7614 Cedar Ro				2122	22			-	State		
11. Marital Status	12. Was Decede Armed Force	nt Ever in U,S.	13.	Was Decedent of Yes, specify Co	Hispanic Origin ban, Mexican, P	? (Specify Ye uerto Rican,	etc.)		e - American I k, White, etc.	ndian,	
1 Never Married 2 Marri 3 Widowed 4 Divorced		<b>∑XN</b> o		1□ Yes 2ŪN	o Specify:			Specify	White		
15. Decedent (Specify only highes	s Education		16a. Deced	dent's Usual Occ	upation	working	16	b. Kind of Bu	usiness/Indust	У	
Elementary/Secondery (0-12)	College (1-4d	or 5+)	_	kind of work dor DO NOT use reti		WUINING					
8			Cran	e Operat	or			sethle	ehem St	eel	
17. Father's Name (First, Middle,	.ast)				18. Mother's			iden Sumam	19)		
Aleck Powell					Mar	y Wall	.ey	ELE			
19a. Informant's Name/Reletions	nip (Type, Print)		19b. Mailir	ng Address (Stre	et end Number o	r Aural Aout	e Number, C	ity or Town,	Stete, Zip Coo	de)	
Leonard Powell	L / son		7614	Cedar I	RD. Ba	ltimor	e, MD	21222	2		
20a. Method of Disposition		0.000	e of Dispo	sition (Neme of matory or other p		Date			City or Town,	State	
1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St		ite		Cremator		10/4	(00 R	eltsvil	le. MD		
21. Signatura of Funeral Service I	**			2. Name and Add		20/-1/	00   24		20,12		
Part 1. finter the disease, or nock or heart failure. List	complications that cause	sed the death.	Do not ent	AFA Step 8717 Gi	hen D. een Pas ying such as car	Lonrma tures rdiac or respi	DR., iratory arrest	.A. Towso	on, MD	21286 proximate erval Between	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	Due to (or a	s a consec	quence of):							
resulting In death) Last	d	Due to (or a:	s a conseq	quenca ory.							
Part II. Other significant conditio	ns contributing to deat	h but not resulti	ng in the u	nderlying cause	given in Part I.	2				csuse of deal	
						24	ta. Was an a performe		availal	eutopsy finding ole prior to etion of cause th?	
							1 Yes	2 No	1 🗆 Ye	s 2 No	
25. Was case referred to medical					26. Place of	Death (Che	ck only one)				
examiner?	Hospital:	atient 2 EF	3/Outpaties	nf 3 DOA	Wher:	ng Home 5		a 6 DOth	er (Specify)	1000	
27. Manner of Death  1 Pendin	28a. Date of I (Month,	-	8b. Time of Injury	f 28c. In		28d. D	escribe how			10.57	
2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	ot ho	Injury - At hom etc. (Specify)	e, farm, str	reet, factory, offic		28f. Lo	cation (Streety or Town,	et end Numb State)	ber or Rurel Ro	oute Number,	
29a. Certifier 1 Certifyin (Check only one) 1 Medical I	Physicien: To the be examiner: On the basis and manner	s of examination	edge, death n and/or in	h occurred at the vestigation, in m	time, date and p y opinion, death	place, and du occurred et ti	e to the ceu he time, date	se(s) and ma and place,	anner as state and due to the	d. e cause(s)	
29b. Signature and title of confine	1	_		29c. Lice	nse number		29d	. Date signe	d (Month, De)	, Year)	
Kh	) anno	m			18883	2/		10/9	30	)	
GERRI DAVIS,	mD, 9000	FRANKL	IN 3	DOWARE	DRIVE,	BALTI	MORE	, MD	2123	37	
11. Date filed (Month, Dey, Year)  OCT 6 5	2000 32. Beg	istrar's Signatur	4.	book	w						

DHMH 16 Rev 6/95

Sta Registr

Physici /Medic Examir

Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Manyland Depertment of Health end Mental Hygiena. Important: if item 27 is marked other than "natural", or hema 23a or 28a-f show eny liqury or other traumetic event, the Medical Exemple must be notified as engine.

Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

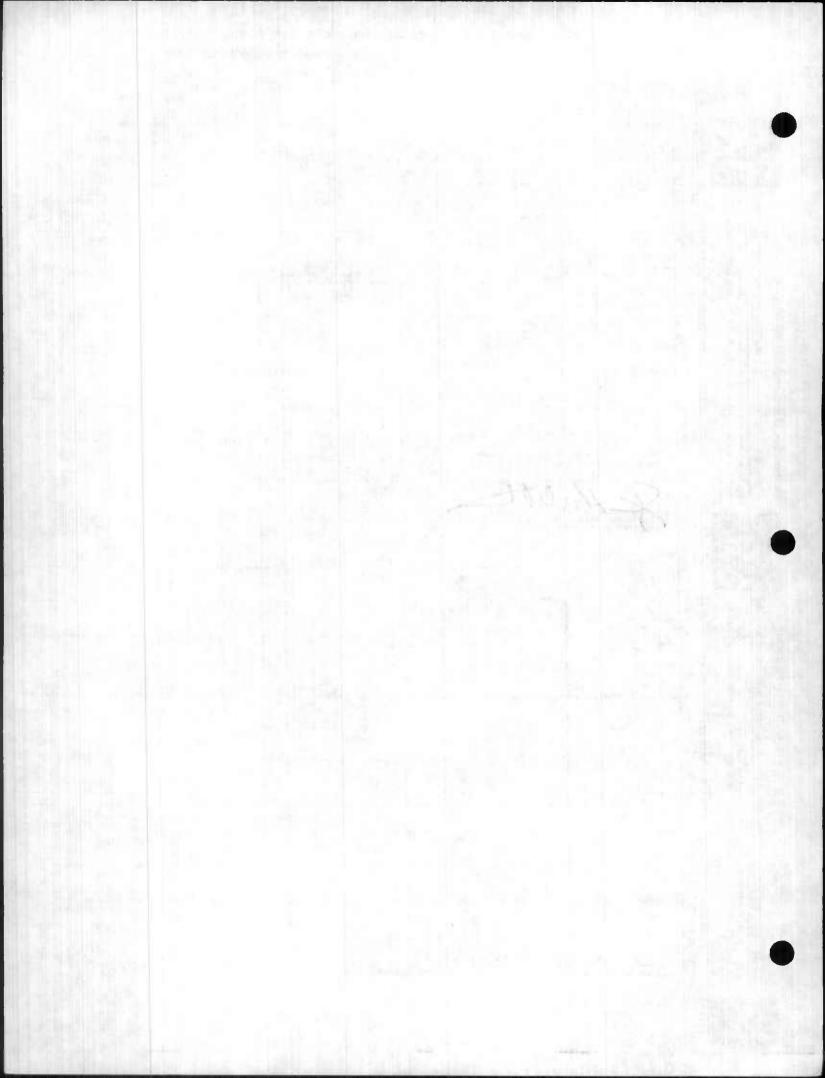
To the Funeral Director: After this certificate hes been signed by the attending physician end completaly filled in by the tuneral director, page 2 should be detached for use as the bunal-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

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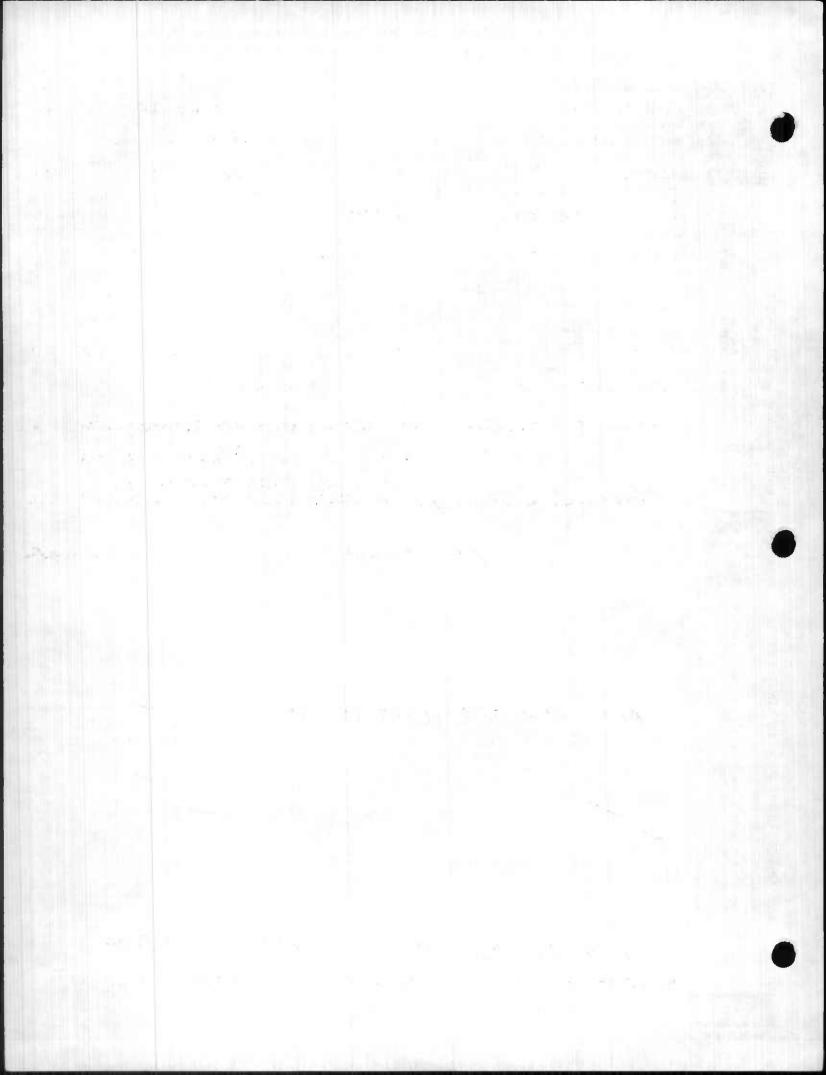


#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dafe of Death 3. Tima of Death 1. Decedent's Neme (First, Middle, Last) Physician DAVID S. PORTNOI OCTOBER 5, 2000 7:10 AM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner 11247 WATERMILL LANE SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Defe of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** Months Days Hours Min 12 M 2 F Yrs. FEB 12, 212-04-3776 88 POLAND Director Usuel Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d, fnside City Limits 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examinal must be notified at MD MONTGOMERY SILVER SPRING 1 ☐ Yes 2 No Directo 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 11247 WATERMILL LANE 20902 BRITAIN Funeral deeth 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas ② No If Yes, Give Year or Dates: 14. Race - Amarican Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2 should be filled within 72 hours efter n end Mental Hygiene. Is marked other than "natural", or ite 1 Never Married 2 Married 1 Yes 2 No Specify: WHITE þ 3☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) BUSINESS OWNER GARMENT MANUFACTURING 12 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fathar's Name (First, Middle, Last) Peges 1 and 2 should be SARAH BEILA SEVITZ ELIYAHU MOSHE PORTNOI 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. fnforment's Name/Relationship (Type, Print) permit. Peges 1 and 2 Department of Health e Important: if item 27 Is any Injury or other tran RONALD KLEINFELD/SON IN LAW 11247 WATERMILL LANE, SILVER SPRING, MARYLAND Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition OCTOBER SHAMSHON, ISRAEL 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State ERETZ HaCHAILM CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licensae EDWARD SAGEL FUNERAL DIRECTION, INC. Sonald ( 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Deeth ath. Do not enter the moda of dying, such as cardiac or respiratory arrest, **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) NEUMONIA 2 week Examiner Examiner and I-transit law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury fhat Initiated events resulting in deeth) Lest Due to (or as e consequenca of) physician ar Box 68760 Physician/Medical Dua to (or as e consequence of): 80 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificent conditions confributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. the 1 Yee 2 No 3 Probably 4 Unknown 6 ARTERIOSCLEROTIC HEART DISEASE þ should b 24e. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to Completed complation of causa of death? hes The 1 Yes 2 AN 1 Yes 2 No certificate or Attending Physician: Be 25. Was case referred to medical exeminer? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA this 27. Manner of Death 28e. Date of fnjury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No death. investigation a Funeral Director: A bletely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Placa of injury - At home, tarm, street, factory, office bullding, etc. (Specify) 4 Homicide Hospital edical 1 🖸 contifying Physician: To the best of my knowledge, death occurred at the time, date end pleca, and due fo the ceuse(s) end menner as stated. 29a. Certifier 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end manner stated. (Check only one) within 2 To the F the the 29c. Licensa numbar 29d. Dafa signed (Month, Day, Year) 29b. Signature and title of certifie 3 30. Nama and address of person who completed cause of death (Item 23e) (Type, Print) 3720 FARRIGUT AUE KENSINGTON, MD 20895 ROSEMBAUM

32 Aegistrar's Signature

Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 32850 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Day Month Yaar **Physician** 705 An 4b. City, Town, or Location of Death 29th RENEE IDA POLLOCK 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) 7/11/12 7. Age (In yrs. last birthday) If Under 1 Yaar Birthplaca (Stata or Foraign Country) Funeral Days 1 M 2 F Months 88 Director 178-03-4347 NY Usual Rasidence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 No Director MONTGOMERY ROCKVILLE the 10a. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 6121 MONTROSE RD. 20852 USA permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Heelth and Mental Hygiene. Important if Hem 27 is marked other than "natural" — and 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 22 XNo If Yas, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-II Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. 1 Nevar Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify p 3\\ Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) HARRY GARFINKEL MINNIE ASOFSKY 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) MICHAEL A. POLLOCK / SON 440 FAIRWAY RD., RIDGEWOOD, NJ 07450 20b. Place of Disposition (Nama of Data 20a. Mathod of Disposition 20c. Location - City or Town, Stata CONGREGATION MERCY & HOPE CEMETERY 1 X Burial 2 ☐ Cremation 3 X Removal Irom Stata 9/29/00 4 ☐ Donation 5 ☐ Other (Specify) POTTSTOWN, PA 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 DANIEL SIMONS se, or complications that caused the death. Do not entar tha mode of dying, such es cardiac or raspiretory errest, List only one cause on each line. Onset and Death **Physician** /Medical Immediata Causa (Final Cardio diseese or condition resulting in death) Examiner Dua to (or as a consequanca ot): Examine d physician end s the burial-transit pronary Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or es a consequence of) P.O. Box 68760 neumonia Physician/Medical Due to (or as a consequence of): for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably A Unknown Contractures à 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Wes an autopsy performed? Completed 15 chemic 2 No 25. Was case referred to medical examiner? 1 Yas 1 ☐ Yas 2 ☐ No vascula-Constipution disease Attending Physicien: Be 26. Placa of Death (Check only ona) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Wursing Homa 5 Residence 8 Othar (Specify) 2 Division of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Medical Certification: Director: After 1 Naturat 5 Pending investigation To the Hospital or Attending within 24 hours after deeth.

To the Funeral Director: After Completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, Ierm, street, lactory, offica building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data end place, end due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha time, data end place, and due to the cause(s) and manner steted. 29a. Certifier (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) onsulo 28th 2000 30. Name end eddrass of person who completed causa of death (Item 23a) (Type, Print) CONSUEG romez Rosa Data filed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

State

Registrar

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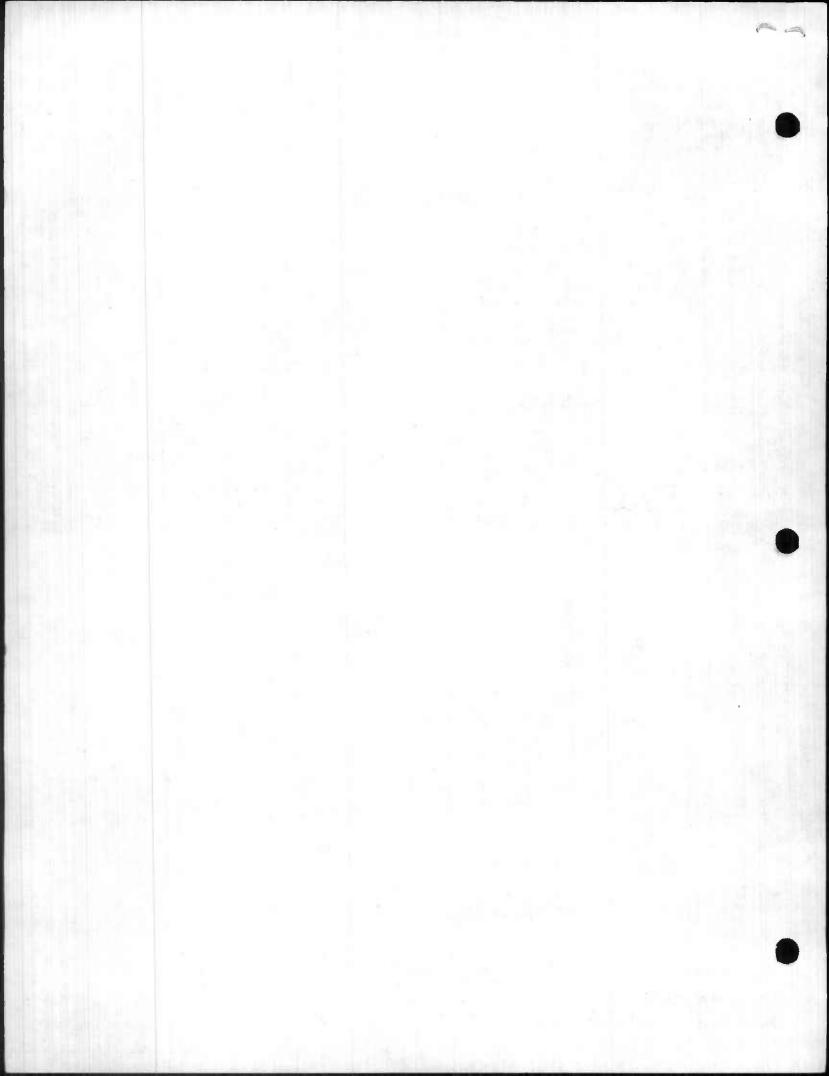
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32. Registrar's Signatura

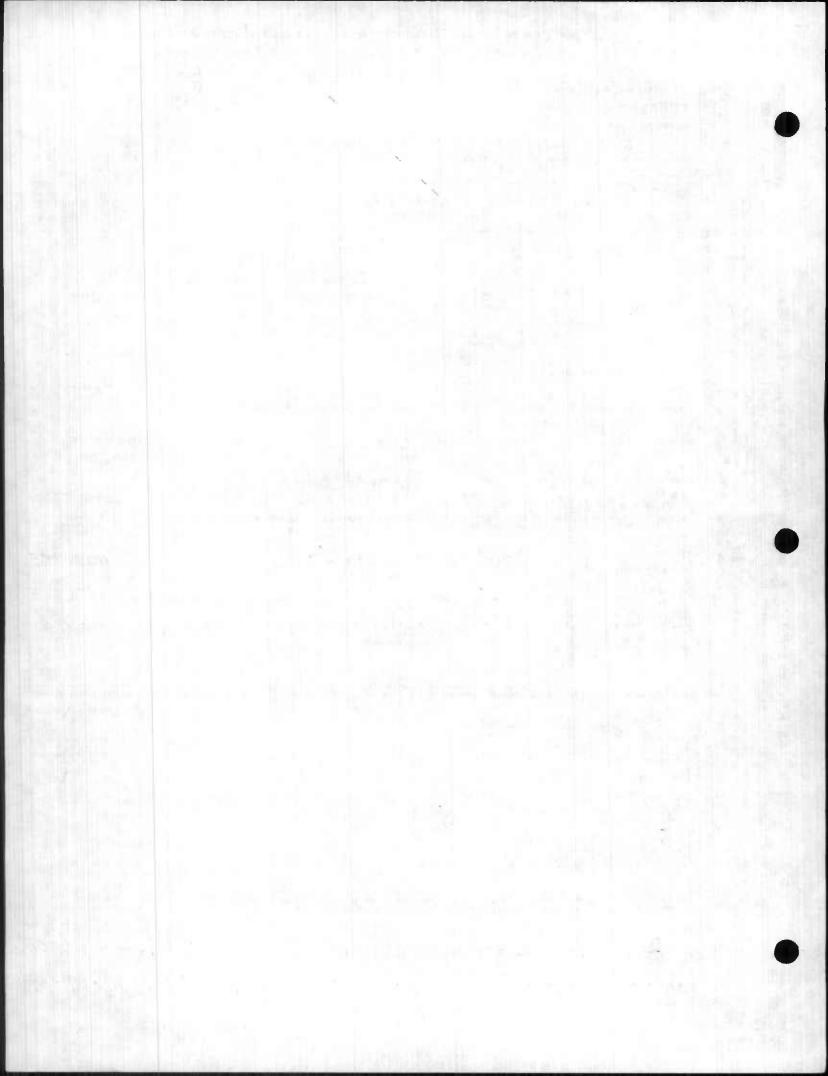
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State of Maryland / Department of Health and Mental Hygiene 00 32851

				Cei	rtificat	e of L	Death			leg. No.		3. Time of Dea	
sician	Decedent's Name (First, Middle, Last)								2. Date of Death Month OCt. 4, 20				
dical	XI										1:11A		
miner	4e Facility Name (If not institution SHADY	GROVE ADV		ST HOS	SPITA		OCKV			MONT	GOMI	ERY	
al or	5. Social Security Number 136–56–6784	6. Sex 7 1□XM 2□ F		last birthday) 43 Yrs.	If Under Months	1 Yeer Days	If Under Hours	24 Hrs. Min.	8. Date of Birth July26	1957	9. Birthp Cour New	place (State or Fo	
	Usual Residence of Decedent	1											
ral Director	Maryland Monto	omery		y, Town or Lo ermanto							1 ☐ Yes 2		
Director	10e. Street and Number 19938 Gateshe	ead Circle			10f. Zip	Code 0876					What Country?  I States		
Funeral	11. Merital Status	12. Wes Deced	ent Ever in U	,S. 13.1	Was Dece	dent of Hi	ispanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)	14. Ra		can Indien,	
by Fur	1 Never Married 2 Mei	If Yes Give	X) No		If Yes, spec		Specify:	n, Puerto	Rican, etc.)  Black, White, etc.  Specify: Black				
Pe	15. Deceder	nt's Education		16a. Deced	dent's Usua	al Occupa	ation			16b. Kind of B	usiness/in	dustry	
plei	(Specify only higher Elementary/Secondary (0-12)	st grede completed)  College (1-4	for 5+)	16a. Deced (Give life.				t of work	ing				
Сотр	12		4	Claim	ns Adj	uste	er			State	Farn	n Ins.	
Be	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Nam	e (First, Middle,	Meiden Sumer			
2	Oscar			Poi	ndext	er	Moz	e11			·	Jackson	
	19a. Informant's Name/Relationship (Type, Print)  Paula Verkuilen (wife)  20a. Method of Disposition  20b. Placa of Disposition (Name of cemetery, cremetory or other placa)								el Route Numbe	r, City or Town	, Stete, Zip	Code)	
									Date	20c. Location	- City or To	own, State	
	Parklawn Memorial Gardens 10/7/00 Rockville, Marylan												
	21. Signature of Funeral Service	1	H	D6	nald	owder	orgw	ardt	Funera	1 Home,	P.A.	land 207	
	23a Parti Enter the disease of	complications that can	seed the deat								TIME Y		
	23a. Part1. Enter the disease, o shock, or heart failure. Lis	only one cause on ea	ch line.	n. Do not on	ior ino moc	io or ayırı	g, oboir as	Darondo	or rouphatory ar	.001,	1	Approximate Interval Betwee Onset and Dea	
1	Immediate Cause (Final	0	1: 40	el to t	.1.	1.	24					/	
	disease or condition resulting in death)  a. Candide arrhythmid  Minute  Due to (or es a consequence of):												
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Examiner	Sequentially list conditions	6. TTY		or as a consec	quence of):					,		yeurs	
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hys				t resulting in the underlying cause given in Pert I.					10	bably 4 Jun			
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0	examiner?	Hospital: 1 🗆 In	patient 2	ER/Outpatier	nt 3 D	Oth Oth	or.		ome 5 Resid		her (Speci	fv)	
Ŀ	27. Manner of Death	28a. Date of		28b. Time of		28c. Injun Worl			28d. Describe h			,,	
atio	1 Natural 5 Pendi 2 Accident invest	igation (Month)	Day roar,	mjory	М		Yes 2	No					
Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Nu City or Town, State)								Street end Num m, Stete)	ber or Rur	el Route Numbe		
edicai C		ng Physician: To the b Examiner: On the bas and manne	is of examina										
2			stateu.		29	c. Licens	e number			29d. Date sign	ed (Month,	Day, Year)	
	29b. Signature and title of certifier  Townshop MA  29c. License number  N51916							Ontol	NOM	4,200			
	39. Name and address of person who completed cause of death (Item 23a) (Type, Print)  39. Name and address of person who completed cause of death (Item 23a) (Type, Print)  A VICIO L. TOMS KO, MD, 1140 Rock VIIIE Pike, PMB 3  31. Date filed (Month, Dey, Year)  32. Pedistrar's Signature & Sporks								UCIUL	101	11000		
	20 Name and addressed as												
	Name and address of person	THIS TO MI	)     (Ide	n 23a) (Type,	Print)	:110	D:L	0. L	mp 21	180	, Li	16 mn	
State	36 Name and address of person attricia	omsko, MI	distrar's Signa	O Ro	ocky	ille	Pik	e, F	MB 34	18, Ro	ckvi	lle, MD2	



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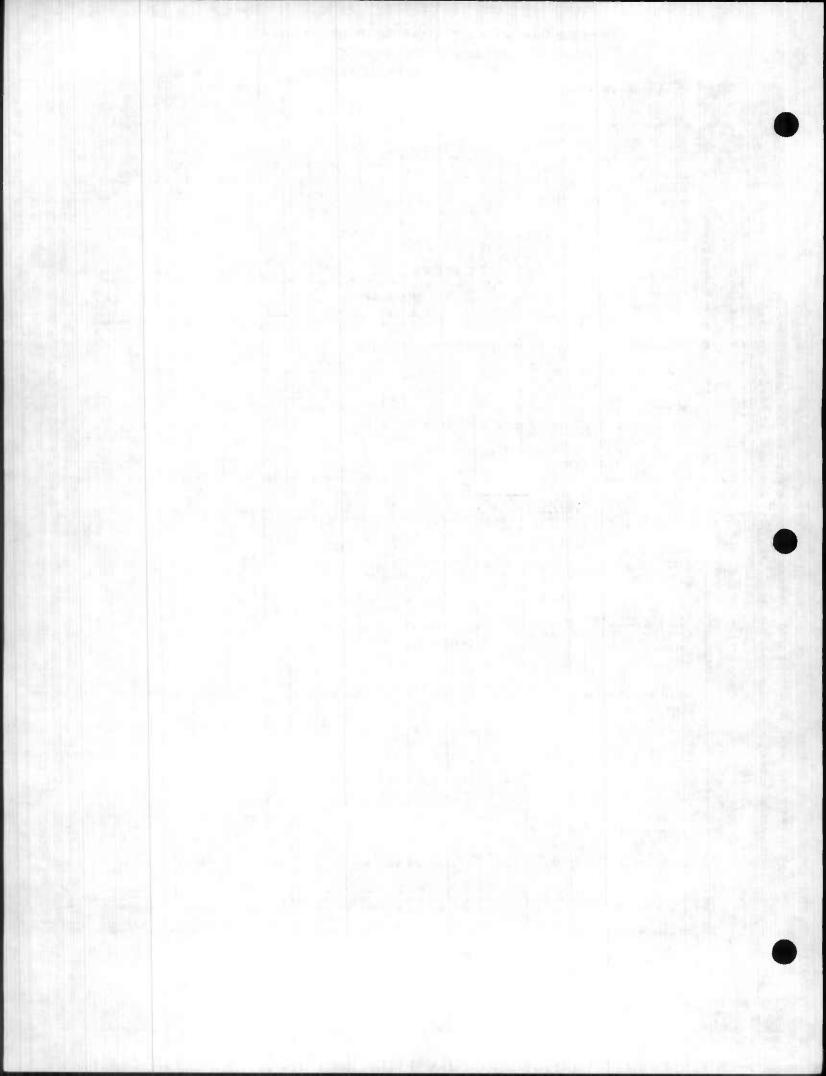
State of Maryland / Department of Health and Mental Hygiene 00 32852

80 B BUREAU DRIV. Social Security Number 6. S 267-45-9725 1  Secular Residence of Decedent Oa. State 10b. County  Maryland Montgom Ob. Street and Number 80-B Bureau Drive 1. Marital Stetus 1. Never Merried 2 Merried 3. Widowed 4. Divorced  (Specify only highest grave before the security only highest grave) Elementary/Secondary (0-12) 1. Fether's Neme (First, Middle, Last) Daniel Wayne Phi 1. Informant's Neme/Reletionship (1) Daniel W. Phillip Oa. Method of Disposition 1. Burial 2. Cremetion 3. D.	Phillips e street end number)  E  E  E  E  E  M  M  2  10  10  11  12  Mery  12  Mery  12  Mery  15  Mery  16  Mery  16  Mery  16  Mery  17  Mery  10  Mery	16e. Dec (Gin life.)  19b. Ma 1635  20b. Plece of Dis cametery, or	Months  cocation  rsburg  10f. Zip C  20  Wes Decede If Yes, specif  1 Yes 2  edent's Usuel e kind of work DO NOT use  Me C	Year Deys  Code  878  Int of Hill  Y Cube  Cocupped done or retired  han	ispanic Origin hours N ispanic Origin n, Mexican, Pi Specify: etion tuning most of 1 18. Mother's	R. Secretary Sec	Dey 1, 20 th 4c. Coun MC inth (ey, Year) 1, 1971  10g. Citizen of USA  14. Ri Bl Spec  16b. Kind of Aut a, Maiden Surres	f What Courter Americal Courter White, with the Courter Willer Wi	olece (State or Foreigntry)  Mexico  10d. tnside City Limit  1 □ Yes 2 ☑ N  ntry?  can indian, atc.  hite  idustry		
B BUREAU DRIVING Social Security Number 267-45-9725 1  Suel Residence of Decedent Oa. State 10b. County  Maryland Montgom Oc. Street and Number 80-B Bureau Drive 1. Marital Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest grace Elementary/Secondary (0-12) 12  Fether's Neme (First, Middle, Last) Daniel Wayne Philip Oa. Method of Disposition 1 Burial 2 Mcremetion 3 1 Daniel W. Phillip Oa. Method of Disposition 1 Burial 2 Mcremetion 3 1 A Donetion 5 Other (Specify County C	e street end number)  E  ex  ex  fix  fix  fix  fix  fix  fix	Gaithe  Gaithe  rin U,S. 13  16e. Dec (Ghiffe.)  19b. Ma 1635  20b. Plece of Discametery, cir	Months  Crsburg  10f. Zip C  20  Wes Decede If Yes, specifi  1 Yes 2!  edent's Usuel e kind of work DO NOT use Mec	Year Deys  Code  878  Int of Hill  Y Cube  Cocupped done or retired  han	ispanic Origin hours N ispanic Origin n, Mexican, Pi Specify: etion tuning most of 1 18. Mother's	OCTOBI or Location of Dee RSBURG drs. 8. Dete of B dron, D July 6  (Specify Yes or N lerto Rican, etc.)	th 4c. Coun MC inth ey, Year), 1971  10g. Citizen or USA  14. Ri Bi Spec 16b. Kind of Aut a, Maiden Surres	on o	MERY  plece (Stete or Foreignity)  Mexico  10d. thislde City Limit  1 □ Yes 2√ N  ntry?  can Indian, etc.  hite  idustry		
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Part Enter the disease, or companies, or heart feilure. List only						nire Aven Maryland	ue 20904				
shock or heart feilure. List only	plicetions the a used the	death. Do not e						1	Approximete		
\ /	one cause on mach line.							1	Intervel Between Onset end Deeth		
mmediate Cause (Final	11										
disease or condition a. Hanging resulting in death)											
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	b	a to for es e cons	or es e consequanca of):								
Sequentially fist conditions, if eny, leading to immediate cause. Enter Undertying											
cause. Entar Underlying Cause (Disease or injury thet initieted events resulting in death) Last  Due to (or es e consequence of):											
ENGLISH PURSU	d										
ert II. Other significant conditions co	ontributing to death but n	ot rasulting in the	underlying ca	use giv	en in Pert I.	23b. Die	d tobacco use o	contribute t	to the cause of deat		
							1 Yee 2 2 No	3 Pro	bably 4 Unkno		
						24a. We	s an eutopsy	91	ere autopsy findings vailable prior to		
								of	ompletion of cause ideath?		
						127	Yes 2 No	1.1	AYes 2□ No		
5 Was case referred to medical					26 Place of			-			
examiner?	Hospitel:	2□ EB/Outpati	ant 2[] DO	Oth	or:			What (Speci	M CCENTE		
	28a. Date of Injury	28b. Time		_		-					
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3 Suicide 6 ☐ Could not be	10-01-90			office		28f. Location	(Street and Nut	mber or Aur	ral Route Number,		
4 Homicide											
9a Cartifier 1 Cartifying Ph				the tin	ne date and n			77			
(Check only 2 Medical Exam	niner: On the basis of ex	aminetion end/or	nvestigation, i	n my o	plnion, deeth o	ccurred at tha time	, dete end plec	e, end dua t	to the ceuse(s)		
	and mornior states										
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Aliph 1	n V La	chi	50	0.	C.M.E.		OCTOBE	ER 2,2	2000		
	completed cause of death	(Item 3a) (Typ	Print)								
O. Name and eddress of person who	- completed causa of deeli	. (									
O. Name and eddress of person who of Stephen S, 1  1. Dete filed (Month, Day, Year)	2 a den + 2 32. Registrer's	2, 1	11 Penr	n St	treet,	Baltimore	e, Mary	Land 2	21201		
	Sequentially fist conditions, fory, leading to immediate ause. Enter Underlying Lause (Disease or Injury het initiated events esulting in death) Last  Pert II. Other significant conditions of the conditions of	Sequentially fist conditions, form, leading to immediate cause. Enter Underlying Lause (Disease or injury het infleted events esulting in death) Last  Due to the significant conditions contributing to death but not be considered to medical examiner?  The significant conditions contributing to death but not be considered to medical examiner?  Manner of Death  Manner of Death  Month, Day You will be considered to medical examiner. Suicide a contributing to death but not be considered to medical examiner. Suicide a contributing to death but not be considered to medical examiner. Sea. Date of Injury (Month, Day You be considered to medical examiner. Sea. Date of Injury (Month, Day You be considered to medical examiner. Sea. Place of Injury building, etc. (2)  Per II. Other significant conditions contributing to death but not be considered to medical examiner?  The significant conditions contributing to death but not be considered to medical examiner?  The significant conditions contributing to death but not be considered to medical examiner?  The significant conditions contributing to death but not be considered to medical examiner?  The significant conditions contributing to death but not be considered to medical examiner?  The significant conditions contributing to death but not be considered to medical examiner?  The significant conditions contributing to death but not be considered to medical examiner?  The significant conditions contributing to death but not be considered to medical examiner?  The significant conditions contributing to death but not be considered to medical examiner?  The significant conditions contributing to death but not be considered to medical examiner?  The significant conditions contributing to death but not be considered to medical examiner?  The significant conditions contributing to death but not be considered to medical examiner?  The significant conditions contributing to death but not be considered to medical examiner?  The significant conditions contributing to death but not be c	Dua to (or as e considerable properties)  Sequentially fist conditions, form, leading to immediate cause. Enter Underlying Lause (Disease or Injury het inflieted events esulting in death) Last  Due to (or es e consection of the conditions contributing to death but not resulting in the examiner?  The properties of the conditions contributing to death but not resulting in the examiner?  The properties of the conditions contributing to death but not resulting in the examiner?  The properties of the conditions contributing to death but not resulting in the examiner?  The properties of the conditions contributing to death but not resulting in the examiner?  The properties of the conditions contributing to death but not resulting in the examiner?  The properties of the conditions contributing to death but not resulting in the examiner?  The properties of the conditions contributing to death but not resulting in the examiner?  The properties of the conditions contributing to death but not resulting in the examiner?  The properties of the conditions contributing to death but not resulting in the examiner?  The properties of the conditions contributing to death but not resulting in the examiner?  The properties of the conditions contributing to death but not resulting in the examiner?  The properties of the conditions contributing to death but not resulting in the examiner?  The properties of the conditions contributing to death but not resulting in the examiner?  The properties of the conditions contributing to death but not resulting in the examiner?  The properties of the conditions contributing to death but not resulting in the examiner?  The properties of the conditions contributing to death but not resulting in the examiner?  The properties of the conditions contributing to death but not resulting in the examiner?  The properties of the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the condit	Dua to (or as e consequence of):  Sequentially fist conditions, ferry, leading to immediate cause. Enter Underlying het infleted events esulting in death) Last  Due to (or es e consequence of):  Due to (or es e	Dua to (or as e consequence of):  Dua to (or es e consequence of):  Due to	Due to (or as e consequence of):    Due to (or as e consequence of):	Due to (or as e consequence of):  Due to (or es e consequence of):  Due to	Due to (or as e consequence of):  Due to (or es e consequence of):  Due to	Due to (or as e consequence of):  Due to (or es e consequence of):  Due to (or es e consequence of):  Due to (or es e consequence of):  C. Due to (or es e consequence of):  1		

DHMH 16 Rev 6/95

Registrar

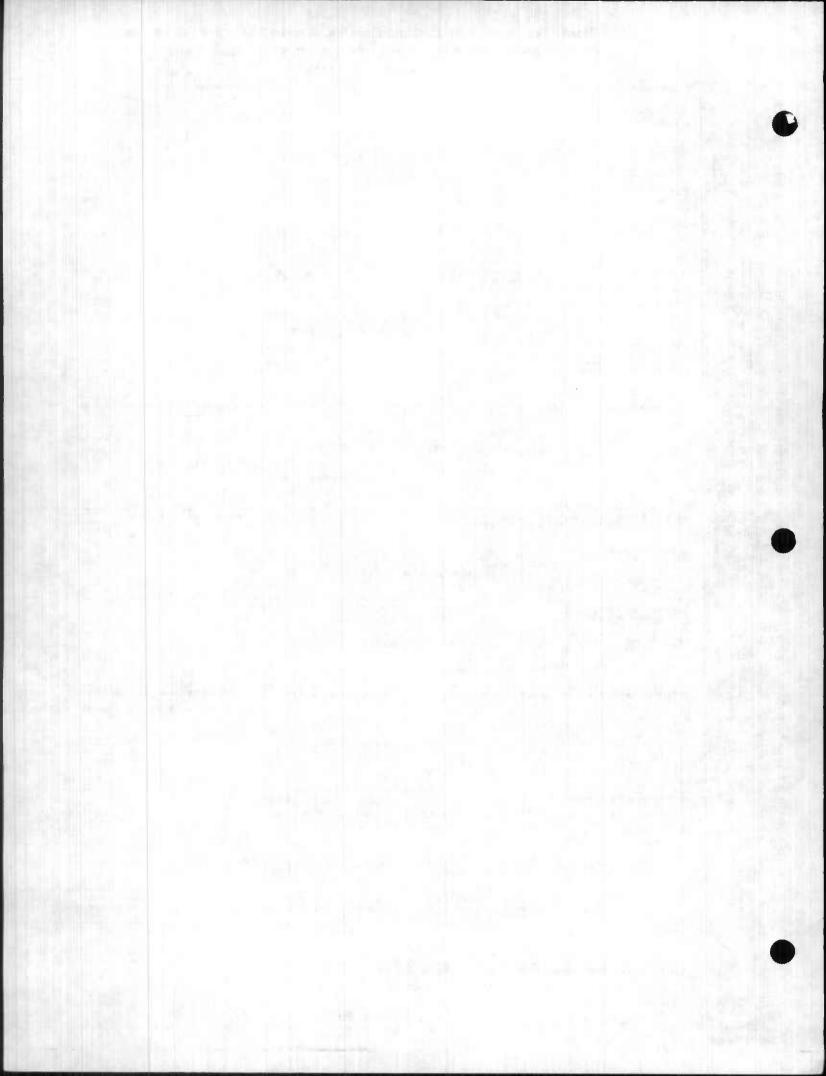
**ORIGINAL** 



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

				tificate of		-	J. No.	0 0	2000
Dhualalan	1. Decedent's Nema (First, Middla, La	est)				2. Date of Death Month	Dey	Yaar 3	3. Time of Death
Physician /Medical	Margaret Frances	Parlon				Septemb			3:00 am
Examiner	4s Facility Name (If not institution, given	ra street and number)			4b. City, Town, or L		4c. County		
e Administra	Montgomery Hospi	ce - Casev H	01150		Rockville Montgomery				
uneral			yrs. lest birthdey)	If Undar 1 Yeer	If Undar 24 Hrs.	8. Deta of Birth (Month, Day,			a (Steta or Foreign
ctor	577-01-7919	1□M 2X0F	83 Yrs.	Months Deys	Hours Min.	Nov 12,	1916		Carolina
	Usuat Residence of Decedent								
	10a. Steta 10b. County	10	c. City, Town or Loc	ation				10d.	Inside City Limits
to	Maryland Montgom	erv	ilver Spr	rina			1 □ Yas 2 🔀		
Director	10e. Street and Number	CI,	IIVCI bpi	10f. Zip Coda		10	g. Citizen of V	/het Country	?
	14564 Kelmscot D	-d		20006		III			
	11. Marital Status	12. Was Decedent Eve	rin U.S. 13. V	20906	Hispanic Origin? (Sp	US pecify Yas or No-		- Amarican	Indien,
	1 Never Married 2 Married	Armed Forces? 1 ☐ Yas 2 ☐ No	lf	Yas, specify Cub	ean, Maxicen, Puerto	Rican, atc.)		Black, Whita, atc.	
	3  Widowed 4 □ Divorced	If Yas, Giva Year or Datas:	1	☐ Yas 2 🗓 No	Specify:		Specify	Whit	e
ŀ	15. Decedent's E		16a Deced	ant's Usuai Occu	pation	11	6b. Kind of Bu	sinass/Indus	itry
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	John Samuel Ledf					t E. Wing		O-4- 7- O-	- d- 1
	19e. Informant's Name/Reletionship		24		t and Number or Ru				
	Bonnie J. Hummer		2405 20b. Place of Dispos	1/2 20tl	Street.	NW, #101	, Wash	ington	DC20009
	20a. Mathod of Disposition 1 ☐ Buriat 2 ☑ Cremation 3 ☐	20c. Location - City or Town, Stata							
	4 □ Donation 5 □ Other (Speci		Metropoli	tan Crei	natory	9/29/00 A	lexand	ria, V	'A
	21. Signature of Funeral Service Lice	nsee		Neme end Addr				_	
	Vais Vila				. Collins				MD 20001
	23a. Parti. Enter the disease, or con sheck, or heart failure. List only	plications that coused the	daath. Do not enta	r the mode of dy	rsity Blvding, such as cardiac	or respiratory arres	ver sp	i A	pproximete
	sheck, or heart failure. List only	ona ceusa on aach lina.							tarval Batween nset end Deeth
	Immediate Causa (Final								
	disaasa or condition rasulting in death)	a Cancer o						18	months
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		b							
	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	Du	a to (or as a consequ	uence ot):					
	Cause. Enter Underlying Ceuse (Disease or injury that initiated events	c		-					
	resulting in death) Last	Due	to (or es e consequ	uance of):				- 1	
The state of the s		d							
	Part II. Other significant conditions	contributing to death but n	ot rasulting in the un	derlying ceusa g	ivan in Part I.	23b. Dtd tot	acco uas co	ntributs to th	ne causs of death?
						1 □ Ye	No No	3 Probel	bly 4 Unknown
-									
						24e. Wes en perform	autopsy ed?	evaile	eutopsy findings abla prior to
1								of de	oletion of causa ath?
						1 ☐ Yas	2X No	101	res 210 No
1	25. Was cese referred to medical				26. Place of Des	th (Check only one	)		
-	examiner? 1 ☐ Yas 2 ☒ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatien	t 3D DOA	16	oma 5□ Rasidar		ar (Specify)	Hospica
	27. Menner of Death	28a. Data of Injury	28b. Tima of	28c. tnje		28d. Describe ho			nospice
	1 Naturat 5 Pending investigation	(Month, Day Y	ear) Injury		ork? ]Yes 2 □No				
	3 Suicide 6 Could not 8	On Disco of Injury	At home farm str			28f. Location (Str.	aat and Numb	er or Rural F	Routa Number,
	4 Homicide determined	building, atc. (3		City or Town,					
	00- 0-4E 4E0 0-4E m	T				and due to the co	una/a) and m	anne on etat	ad .
29e. Certifier (Check only one)  29e. Certifier (Check only one)  1X Certifying Physician: To the best of my knowladga, daeth occurred et the time, date end place, end due to the ceuse(s) end manner as stated.  2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, daeth occurred et the tima, data and place, and due to the cause(s) and manner stated.									
		and mannar stated		20e Lines	isa number	20	d. Data signe	d (Month De	v Veer
	29b. Signatura end titla of certifier	7 pi.		29C. Licar	isa number	23	u. Data signe	o (month, De	19, 1041)
-	C. F	- Leve	MD	D 094	470	S	eptemb	er 29,	2000
	30. Name and address of person who	completed ceusa of daat	(Item 23a) (Type, I	Print)					
	E. P. Libre, MD	10400 Conn	ecticut A	ve., Ker	nsington,	MD 2089	5		
ŕ	31. Data filed (Month, Day, Year)	32. Registrar's		0					
te	OCT 0 2 2				1.				

DHMH 16 Rev 6/95



#### Please Type or Print in Biack Indelible Ink. Assure Ali Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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00	0	6	Ü	0	ĺ,

2000

Physici /Medic Examir	cal	4
Funeral Director	2	5
and 21215-0020  d be tiled within 72 hours after death with the Maryland intal Hygiene, and other than "natural", or items 23e or 28e-f show c event, the Medical Examiner must be notified at	To Be Completed by Funeral Director	1 1
Mary d 2 shou in and M 7 is mark traumati	-	1
Nore, If then?		2
Baltin permit. Pa Department important any injury ance.		2

				001	uncat	, 01	Doutil			Heg. No.			
Physician /Medical	1. Decedent's Name (First, Mid Dolores Mangr						17.5		2. Date of De Month Octobe	Dev	Yeer 000	3. Time of Death 810am	
Examiner	4e Fecility Name (If not institut 802 Kenbrook		er)						ocation of Death pring	4c. Count	y of Death		
Funeral Director	5. Social Security Number 478-12-3800	6. Sex 7.	Age (In yrs. last	birthday) 8 <sub>Yrs.</sub>	If Under Months	1 Yeer Deys		24 Hrs. Min.	8. Dete of Bir (Month, Da Jan 2	th y, Year) 0, 1922	9. Birth Cou IA	plece (Stete or Foreigntry)	
_	Usual Residence of Decedent					1							
that show odified at ector	MD Mon:	y cgomery	10c. City, To Silv		cation princ							10d. Inside City Limit 1 ☐ Yes 2 ☐ N	
190 DE	10e. Street end Number				10f. Zip	Code				10g. Citizen of Whet Country?			
at be	802 Kenbrook	Dr			209	02				United	United States		
"natural; or items 23s or 28s4 sh edical Examiner must be notified. ieted by Funeral Director		Armed Forces?  1 Never Merried 2 Married   1 Yes, 2 No   1 Yes, Give   Yeer or Detes:					Hispenic Ori pan, Mexical Specify:	n, Puerto	ecity Yes or No Rican, etc.)	Ble	Race - American Indien, Bleck, White, etc.		
dical	(Specify only high	ent's Education lest grade completed)	16	Sa. Deced	lent's Usue kind of wo	l Occu	pation during mos	it of work	ring	16b. Kind of E		ndustry	
wer than It, the Ma Compl	Elamantary/Secondery (0-12	or 5+)	(Give kind of work done during most of work life. DO NOT use retired)  Homema ker										
t of Health and Markal Hygions. If Hern 27 is marked other than or other traumatic event, the M	17. Fether's Neme (First, Middl		18. Mother's Name (First, (UNKNOWN)						Middla, Maiden Surneme)				
27 is mar 27 is mar c traumal	19e. tnformant's Neme/Reletion Donald Palmer			19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State 802 Kenbrook Dr, Silver Spring, MD 209									
nent of Health and Mental Hygione. Int: It lean 27 is marked other transition ary or other traumatic event, the Me	20e. Method of Disposition  1 □ Buriel 2 □ Cremetion 4 □ Donetion 5 □ Other		ceme	Plece of Disposition (Neme of cametery, cremetory or other plece) hesapeake Crematory					oct 5 2000	20c. Location Beltsv			
Departi Imports any inje	21. Signeture of Funerel Bervio	P. He Q=	1	22			ass of Facili neral . Aven	k Cr	emation Silver	Servic Spring,	ces , MD		
nysician Medical	23a. Pert1. Enter the di dase, shock, or heart fall ore. Li	st only one cause on eed Respi	sed the deeth. D			e of dy	ing, such as	cardiec	or respiratory e	rrest,	1	Approximete Intervel Between Onset and Deeth	
xaminer	disease or condition resulting in deeth) a.												

Sequantially list conditions, if eny, laeding to immedieta cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last

	Onset and Deeth
Respiratory Failure	Weeks
Due to (or as e consequence of): Chronic obstructive lung disease	Years
Due to (or es e consequence of):	
Due to (or es e consequence of):	

Physician/Medical Examiner 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Congestive heart failure Be Completed by 24b. Wera autopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? coronary artery disease 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) Medical Certification: To 1 Yes 2 No 27. Mennar of Death 28c. tnjury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Delatural 1 ☐ Yes 2 ☐ No 2 Accidant 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 3 Suicide 6 Could not be datarmined 28e. Place of tnjury - At homa, farm, street, fectory, office building, atc. (Specify) 4 Homloida

Hospital or Attending Physician: The lew requires that the death certificate be executed 24 hours after death. ed by the attending physicien end detached for use as the buriel-tran Division of Vital Records, P.O. Box 68760, yd bengis should be page 2 Director: After this certific d in by the funeral director. filled in by To the Hospital within 24 hours a To the Funeral Completely filled.

3	P	8
	3	0

1 Pcertifying Physician: To the best of my knowledga, deeth occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and Mile of certifier

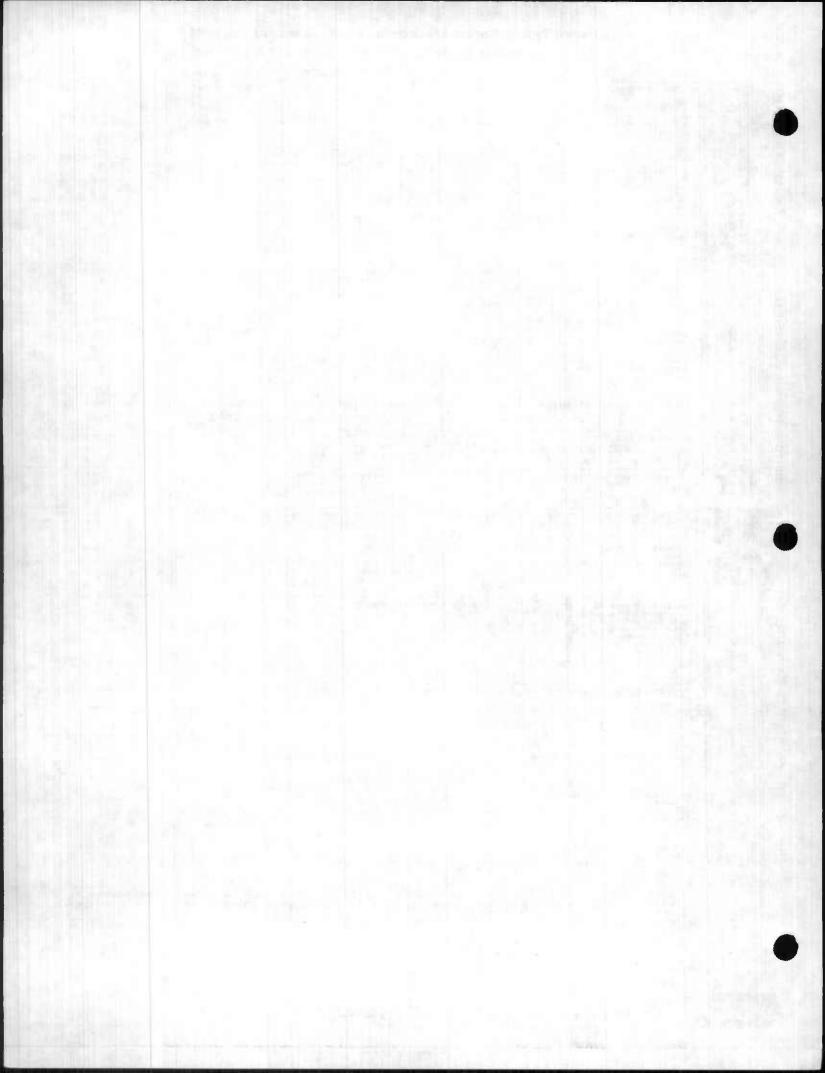
M.D. 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

Irnest S. Oser M.D. 10301 Georgia Ave #304, Silver Spring, MD 20902

State Registrar

31. Dete filed (Month, Day, Year) OCT 6 4 Registrer's Signeture

D03792



# BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

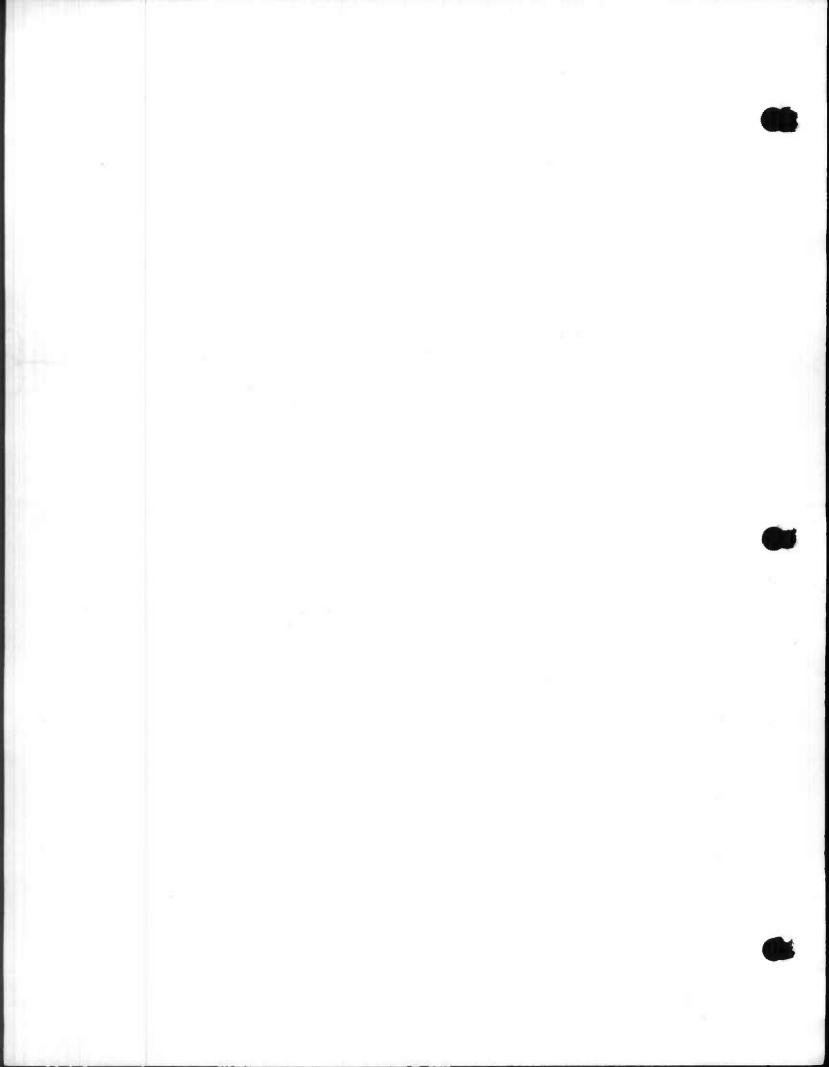
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1, 2, schould
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH

REG. NO.

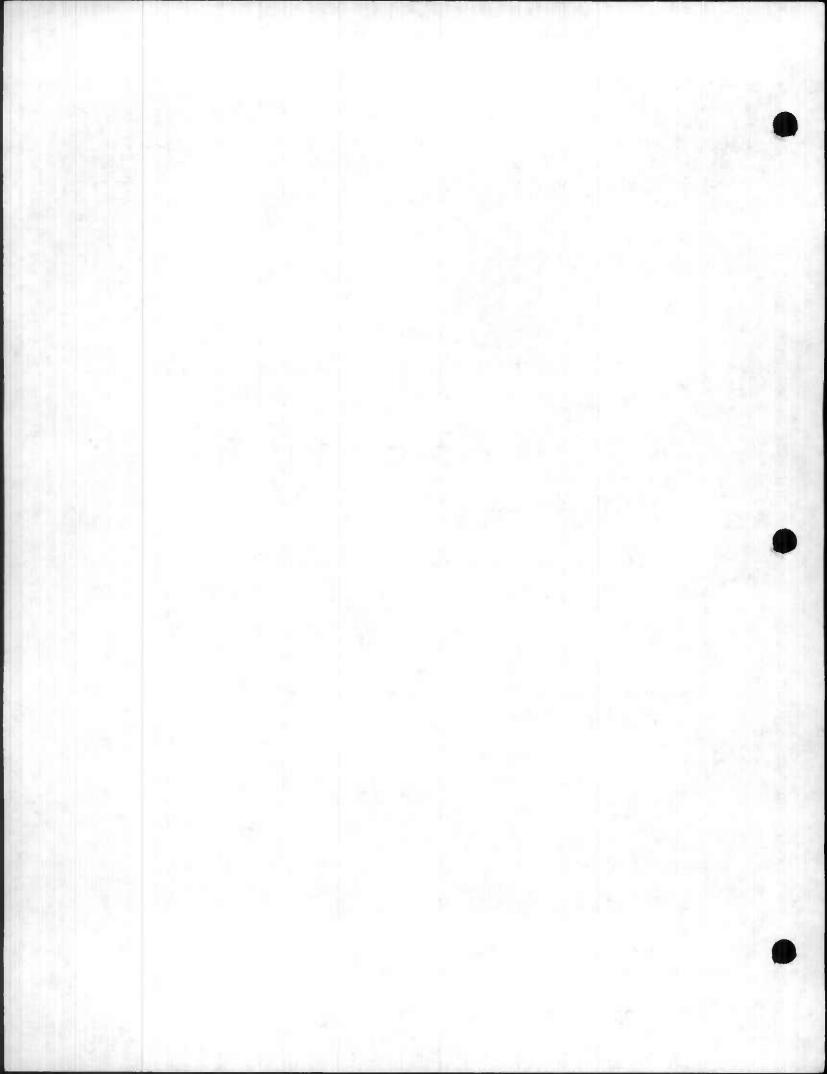
	1. DECEDENT'S NAME (First, Middle, Last) Marjorie								2. DATE OF DEATH MONTH DA	v	YEAR	3. TIME OF DEATH
			oss						Sept. 29,	200		6:50 P.M. M
	4. SOCIAL SECURITY NUMBER		NGE (In yrs. las		IF UNDER	DAYS	IF UNDE	R 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTH	IPLACE (State or Foreign
	214-03-6257	1 M 2 🗹 F	88	YRS.					Mar. 16, 191			land
~	9e. FACILITY NAME (If not institution, give				95. CITY,	TOWN	OR LOCAT	ION OF DE	ATH	9c. COL	JNTY OF D	EATH
DIRECTOR	Mallard Bay Nu	rsing Home			Ca	ambr	idge	3		Do	rche	ster
E I	10a. STATE 10b. COUN	TY		10c. CITY,	TOWN O	R LOCAT	TION					10d. INSIDE CITY
ā	Maryland Doro	chester			Caml	orid	lge					LIMITS?
AL	10e. STREET AND NUMBER					_	ZIP COD	E		10g. CIT	IZEN OF	VHAT COUNTRY?
BY FUNERAL	520 Glenburn						216	513		US	SA	
5	11. MARITAL STATUS  1 News Merried 2 Merried	12. WAS DECEDENT EVE FORCES? 1 1	ER IN U.S. AR	MÉD O	13. V	AS DEC	ENDENT	OF HISPAN	C ORIGIN? (Specify Yea , Puerto Ricen, etc.)	or No-	14. RACI	- American Indian, k, White, etc.
₽	3 Widowed 4 Divorced	IF YES, GIVE WAR O	OR DATES					Specify			Spec	ity:
	15. DECEDENT'S ED	JCATION	16a, DE	CEDENT'S U	SUAL OC	CUPATIO	ON		16b. KIND OF BUS	INESS/IN	DUSTRY	Black
COMPLETED	(Specify only highest grad Elementary/Secondary (0-12)	completed)	(Gi	ve kind of wo Do NOT use	rk done di	uring mo	st of worki	ing	No. Kind or add	1111237111	DOSTRI	·
릴	8	50.000 (14 6) 54)	- C	rab P	icke	r			Seaf	ood		
Ö	17. FATHER'S NAME (First, Middle, Last)			LUD I	ACITE.		16. MOT	HER'S NAM	ME (First, Middle, Meiden	Sumame)		
BE (	Wilbert	Travers						Susa	an J	ohns	on	
TO E	19e. INFORMANT'S NAME (Type/Print)		196	MAILING A	DDRESS	(Street a	nd Numbe		oute Number, City or Town			
-	Brenda Cephas	/ Neice	7	04 Bo	1dsb	oro	ugh	Ave	Cambridg	e Ma	rvla	nd 21613
	20e. METHOD OF DISPOSITION 1 Surial 2 Cremetion 3 Ren	noval from State	20h PLACE A	NO DATE OF	DISPOSI	TION /N=	menf		DATE 200 LOG	CATION -	City or To	wn, Stata
	4 Donation 5 Other (Specify)		Meek	ins N	eck	Cem	eter	У	10/7/2000	Ch	urch	Creek Md.
	21. SIGNATURE OF FUNERAL SERVICE L	CENSEE						mith	ылу Funeral H			
					P	.0.	Box	1687.	Easton, M.	arv1	and :	21601
	23. PART Enter the diseases, 62 shock, or heart feilure.	List only one cause of	used the da	eth. Do no	t anter t	tha mo	de of dy	ing, auch	ss cerdiac or reepi	ratory ar	reat,	Approximate
1	IMMEDIATE CAUSE (Final		o contraction									Interval Between Onset and Death
	disease or condition resulting in death)	· Se	DS/S		_							days
		DUE TO (OR	AS A CONSEC	UENCE OF):								
S	Sequentielly list conditions,	b. De	CUBIT AS A CONSEC	75								Months
EA!	if sny, leading to immediata cause. Enter UNDERLYING	DOE TO TON	0 601	DENCE OF	tel	11.						1.4.0
CERTIFICATION	CAUSE (Diseese or injury that initiated events	DUE TO (OR	AS A CONSEC	UENCE OF):	Ch	LIH	15					Hears
E	resulting in desth) LAST	4										/
	PART II AND II MI											
MEDICAL	PART ii. Other eignificant condition	ns contributing to dee	th but not re	suiting in	the uno	lerlying	ceuse	given in F	Part i. 24a. WAS AN . PERFOR		246	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
ă							_		1 YES 2	(E-110		OF DEATH?
on 11	DID TODA CCO LICE COLD											1 - YES 2 - NO
AN	DID TOBACCO USE CONT	RIBUTE TO CAUSE		E OF DEATH			UNC	ERTAIN				
PHYSICIAN:	EXAMINER?	HOSPITAL:		-	OTHER							
¥	27. MANNER OF DEATH	1 Inpatient 2 ER/		28b. TIME		ng Hom 28c. INJ		esidence (	28d. DESCRIBE HOW IN	III EN OC	OHEE	
	1 Natural 5 Pending	(Month, Day, Ye	ar)	INJUI	RY	WO	RK?	NO	200. DESCRIBE HOW IN	JUNT OC	COHED	ŀ
ВУ	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJ	UFIY — At hor	ne, farm, str	eet, facto				28f. LOCATION (Street a	nd Numbe	r or Rumi F	Inute Number
日	4 Homicide determined	building, etc. (	(Specify)						City or Town, State)			,
ET	290. CERTIFIER	ICIAN: To the heat of my k	powledge des	46.0000000				1147				
COMPL		ER: On the best of exemin										and manner so stated
	29b. SIGNATURE AND TITLE OF CERTIFIE											
B	Ma. O	1 -	Was	11	1		29c. LIC	ENSE NUMI	BER	29d. DAT	E SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WI	HO COMPLETED CAUSE OF	DEATH OTEN	27) (Type 0	/		D	3//	0	2	10-3	-00
	Marillan	n N Ma	MODE	111	1	Un	Q I	210	, <1. (	1	1000	to Mi
	31. DATE FILED (Month, Day, Jear)		BIGNATURE	1011	1)	TU	0	TA KN	1 74, 6	um	BKI	me, 1.10.
	OCT 05	2000 50	news	19	•	1						0,
		-		1	-/4	100	160					DUMAN AS Day AND



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				Certific	ate of	Death	1.67	Reg. No.		2000
nysician	1. Decedent's Neme (First, Middle, Las	()					2. Dete of De Month	eath Dey	Yeer	3. Time of Deeth
Medical	Diann Gertrude						Septem	ber 28	2000	2025
kaminer	4a Fecility Neme (If not institution, give	street and number	r)			4b. City, Town, or I	ocation of Deet	h 4c. County	of Deeth	
	The Kent and C	ueen Ann	e's Hosp	ital,		Chester		Kent		
eral	5. Societ Security Number 6. Se	9X 7. A □M 2⊠ F	age (In yrs. lest birt	Yrs. Mont	der 1 Yeer	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, De	3, 1951	9. Birthp	elece (State or Foreigntry)
or	219-56-9098 Usuel Residence of Decedent		49	113.			April	3,1951	Mary	land
	10a. Stete 10b. County		10c. City, Towr	n or Location					1	0d. Inside City Limits
To.	Maryland Queen	Annes	Cont	revill	0					1. Yes 2 □ No
Directo	10a. Street and Number	mnes	Oenc.		Zip Code			10g. Citizen of V	Vhet Cour	ntry?
	107 Holton	Street			21617			USA		
Funeral	11. Meritel Stetus	12. Wes Deceden		13. Wes De	cedent of h	lispenic Origin? (S	pecify Yes or No	- 14. Rac		can Indien,
2	1 ☐ Never Married 2 ☐ Merried	Armed Forces				en, Mexican, Puert	o Rican, etc.)	Bled	k, White,	etc.
by	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Detes	*	1 LI Yes	2 M No	Specify:		Specify	Bla	ck
Completed	15. Decedent's Edi (Specify only highest grad	ucation	16e.	Decedent's U	suel Occup	netion during most of world)	kina	16b. Kind of Bu	usiness/Inc	dustry
nple	Elementery/Secondery (0-12)	College (1-4or	5+)	life. DO NO	Tuse retire	d)	any .			
Co	12		L	ine W	orker			Campbel		oup
Be	17. Father's Name (First, Middle, Last)					18. Mother's Nan	ne (First, Middle	, Maiden Sumem	10)	
To	George Copelar					Algie	Virgi		odd	
	19a. tnforment's Name/Relationship (T	ype, Print)	19b.	. Meiling Addr	ess (Street	end Number or Ru	rei Route Numb	er, City or Town,	State, Zip	Code)
	Charmonque N. Roc	chester/D	aughter			n Street,				
	20a. Method of Disposition 1 MBurlel 2 ☐ Cremetion 3 ☐	Removel from Stet	complex	y, cremetory	or other pla		Dete	20c. Location -	City or 10	own, Stete
	4 □ Donation 5 □ Other (Specify		Rich	Neck			0/4/200	0 Ewing	gtown	,Maryland
	21. Signature of Funerel Service Licens	500 A				ss of Fecility mith Fune	ral Hom	10		
	John A. Fr	ince		P.	O.Box	1687, Ea	ston, Ma	ryland 2	21610	
	23a. Per 1. Enter the diseese, or comp shock, or heart failure. List only of	dications thet cause one cause on each	ed the deeth. Do r	not enter the r	node of dyir	ng, such es cerdiad	or respiretory e	errest,		Approximete Interval Between
Н										Onset end Deeth
	Immediate Ceuse (Finet disease or condition resulting in death)	· a	nohi	Sme	repli	alopat	tes		1 4	3 days
-	Todaking in dooking		Due to (or es e d	consequence	of);	alopat			1	
Examiner		b	ardios	-	ma	ry a	resi	<u></u>		
xar	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	1	Due to (or as a c	consequence	of):	2				
Cal	Cause. Enter Underlying Cause (Disease or injury that initieted events		talus	asu	nal	reus			- 1	
TO	resulting in deeth) Lest		Due to (or es e c	onsequence o	01):					
2		d								
cla	Part II Other eignificant englishes co	estellusting to donth	hut not rosulting le	the underlyin		on in Dad I	225 Did	tohacco use co	ntelbute t	the cause of death
Physician/Me	Part II. Other significant conditions co				ig cause gi	ren in rent i.		Yes 2 No	/	bably 4 Unknow
by P	asthua.	ttype	rteuse	on			10	100 2010	0 2 1 1 0	
		61						en eutopsy	24b. W	ere autopsy findings ailable prior to
Completed							pen	ormed?	CO	mpletion of ceuse death?
E							10	Yes 2 No	15	☐Yes 2☐No
0	25. Wes case referred to medical					26. Plece of Dec				2,00 20,00
0	examiner?	Hospitel: 1 Dinpal	tient 2 ER/Our	tpatient 3	DOA Ott	201:		idence 6 Oth	er (Specif	(v)
ı: ⊥	27. Manner of Death	28e. Dete of In (Month, D	iury 28b. T	ime of	28c. tnju			how injury occur		,,
ate	1 Pending 2 Accident investigation	(Month, D	ay rear) ti	njury M		Yes 2 □ No				
Certification:	3 Suicide 6 Could not be determined	286. Piece of II	njury - At home, fer	rm, street, fac	tory, office			(Street and Numb	er or Aur	al Route Number,
Sen	4 🖂 Hornicide	bulloling, e	яс. (эреспу)				Ony or 10	wii, State)		
	29a. Certifier 1 Certifying Phy									
edical	(Check only 2 Medical Exami	and menner s	or examinetion end steted.	d/or investiget	ion, in my c	ppinion, deeth occu	rred et the time,	date end ptece,	end due to	o the ceuse(s)
Σ	29b. Signeture end title of certifier				29c. Licens			29d. Date signe	1	1110
	166/Mun	-, Mi	) .	IN.	02	1313		10/2	100	
	30. Neme and eddress of person who c	ompleted cause of	death (Item 23a) (	Type, Print)		0	0.1		-	
	KIN K. WI	iN,	415 1	Vash	upto	n Hare-	Clast	elown	m	0 21620
ate	31. Dete filed (Month, Day, Year)	32. Regis	trer's Signeture	1.	A					
strar	OCT 0 5 200	Alp	server 1	M	20. 11	1 ,				

DHMH 16 Rev 6/95



State Registrar

DHMH 16 Rev 6/95

20

29b. Signature and title of cartifier

30. Name and address of person who

MARYDMAS

31. Date filed (Month, Day, Year)

Morre

impleted cause of death (Item 23a) (Type, Print)

Transa

32. Registrar's Signature

yw

Kolou

6 2000

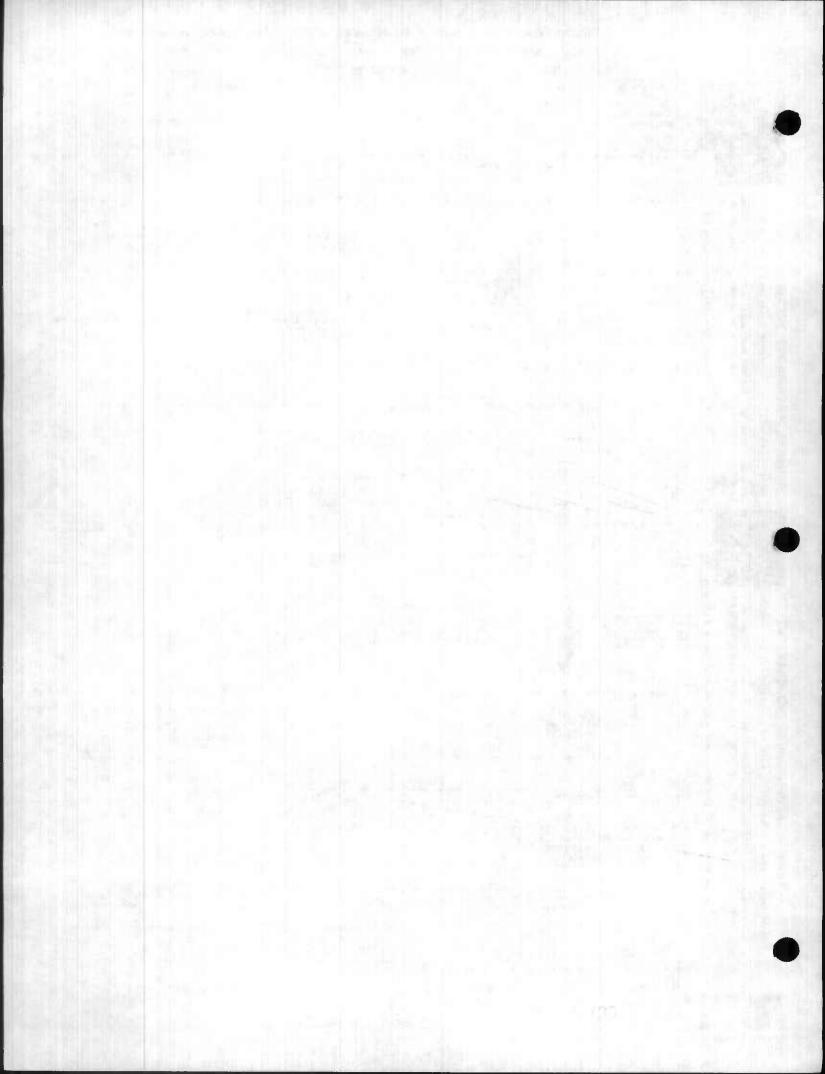
29c License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

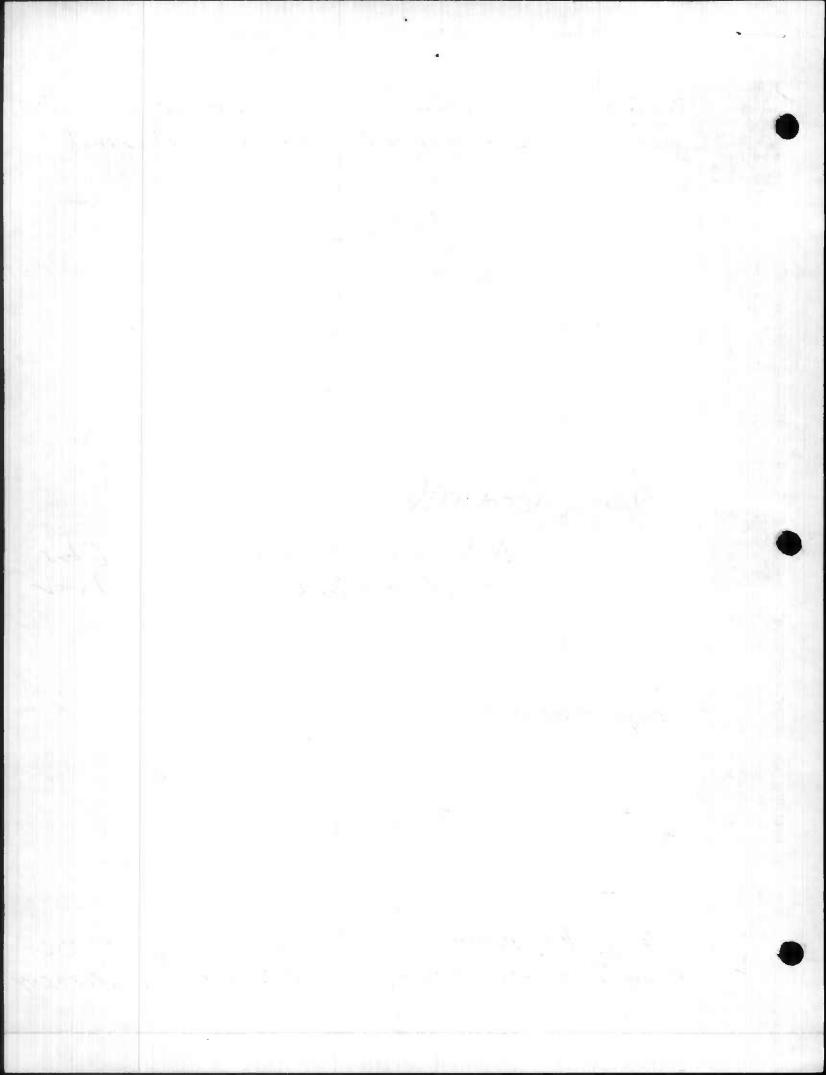
September 29, 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 3 2 8 5 8

			11.00		Certif	icate of	Death		Reg. No.	V 600	. 0 0 0
Dharala		Decedant'a Nama (First, Middla, Last)	D 00		F , 5			2. Data of De		Vaar	3. Tima of Death
Physici /Media		rennie	Kytt.	12	7			Jert	257	000	40/AM
Examir	100	4a. Facility Nama (If not institution, giva stre	eet and number)		. ,	1	4b. City, Town, o	or Location of Death	4c. County	of Death	1
		Howard Co	Gen HE	51	1/4		(0/4)	7515	Ho	W92	-d
Funeral		5. Social Security Number 6. Sex	7. Aga (In yrs			Under 1 Yaar onths Days			th y, Year)	9. Birthpla Country	ce (Stata or Foraign
Director		245-42-4562 1UN Usual Rasidance of Decedant	2X 81		TIS.			May	21, 191	9 Wils	son Co., N
Pw Pw		10a. Stata 10b. County	10c. C	ity, Tow	n or Locati	on				100	d. tosida City Limits
Merylen febow	10	MD Montgomen	S-	ilve	r Spr	ino					1□ Yes 2ĀNo
100 I	rec	10e. Street and Number	<u> </u>			Of, Zip Coda			10g. Citizen of	What Countr	v?
ath with the Meryle 23a or 28a-1 ehov	O	3706 Lamberton Squa	are Road Apr	t. 1		0290	4		USA		,.
ter death with the Meryland itams 23a or 28a-1 show ther man be notified at	by Funeral Director	-	Was Dacedant Ever in I Armed Forcas?				•	(Specify Yas or No arto Rican, atc.)		ce - Amaricar	n Indian,
hours efter ural, or ita	3	1 Never Married 2 Married	Armed Forcas? 1 ☐ Yas 2 ☐ No					arto Rican, atc.)	Bla	ck, Whita, et	c.
ai'.	by	3   Widowed 4 □ Divorced	1 ☐ Yas 2 ☐ No If Yas, Giva X Yaar or Dates:		10	Yas 2. X No	Specify:		Specif	y: B1	ack
"natural".	Completed	15. Decedant's Educat (Specify only highast grada of	ion	16a.	Decedent	's Usual Occu	pation	nakina	18b. Kind of B	uslnass/Indu	istry
2 2 2	npie	Elamantary/Secondary (0-12)	Collaga (1-4or 5+)				during most of w	OTKING			
T the state of the	Co	6			Pick	er			Tob	acco E	Exports
tel Hygi d other event, n	Be	17. Fathar's Nama (First, Middle, Last)						ama (First, Middla,	Maiden Suman	na)	
marked o	10	Robert Hilliard					Penn	ie Bynum			
a e a		19a. Informant's Name/Relationship (Type,		19b				Rural Routa Numb		Stata, Zip C	(lode)
end ealth n 27 ner tu		Pennie Southerland					cton Squa	are Rd. #			Spring, MI
0 0		20a. Mathod of Disposition 1   ☐ Burlal 2 ☐ Cramation 3 ☐ Rem	oval from Stata	camete	ry, cramato	n (Nama of ary or othar pla		Data	20c. Location		
Pag men ant: ury		4 ☐ Donation 5 ☐ Other (Specify)	Re	est	Haven	Cemet	ery	10/7/00	Wilso	on Cou	inty, NC
permit. Pag Department Important: I any injury c		21. Signature of Funaral Sarvice Licansea	1	20	22. Na	ma and Addr	ass of Facility	n Funeral	Commis	o Tm.	
205 20		March 1:16	drad 2	UN				treet Al			
		23a. Part 1. Entar tha disaasa, or complicat shock, or haart failure. List only one of	ions that causad tha dea	th. Do i	not antar th	a moda of dy	ing, such as card	ac or raspiratory a	rrast,	a, VA	22310 Approximata ntarval Batween
Physician	7		_ /							Ċ	Onset and Death
/Medical		tmmadiata Cause (Final disaasa or condition resulting in death) a	Pu / 227	821	SVE		den	75		1	hus
Examiner		resulting in death)			consequen			-			1
pa its	in a	<b>a</b> b	reng	/	+0	71/4	ve			/	SEEV
death certificete be executed et ettending physician end et for use es the buriel-transit	Examiner	Sequentially list conditions,	Dua to (	or as a	consequan	ce of):				- 4	
clan		Sequantially list conditions, if any, leading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants									
sere the the t	edicai	that Initiated avants rasulting in death) Last	Due to (	or as a c	consequen	ce of):					
ling p	2	4									
ettendi for use	Physician/	- V									
igned by the e	/sic	Part II. Other significant conditions contrib	uting to death but not ra:	sulting Ir	n the undar	tying causa g	ivan in Part i.	23b. Did	tobacco use co	ntribute to t	the cause of death?
ed by th detache		hypertent	on					1 🗆	Yes 2□ No	3 Proba	ably 4 Unknown
eigne bed	by	7									
been sign should be	Completed							24a. Was perfo	an autopsy	avalla	a autopsy findings labla prior to
. LI 0	P.						-			of de	pletion of causa eath?
	8							10	Yes 2 No	10	Yas 2□ No
s certificate has director, page 2	Be	25. Was casa referred to medical axaminar?					26. Place of D	eath (Check only o	ona)		
90	10	1 Yes 25 No Hos	pital: 1 Inpatiant	ER/Ou	itpatient 3	BO DOA	har: 4 Nursing	Homa 5 Rasi	dence 6 Oth	nar (Specify)	
ter th neral		27. Mannar of Death 1 Natural 5 ☐ Panding	28a. Data of Injury (Month, Day Year)		Time of njury	28c. inju	iry at ork?	28d. Describe	how Injury occur	red	
efter death.  Director: After  I in by the funer	Certification:	2 ☐ Accidant invastigation					]Yas 2□No				
or Attended of the following t	Ĕ	3 Suicida 6 Could not be data minad	28e. Place of Injury - At h building, atc. (Speci	oma, fa	rm, straat,	factory, office		28f. Location (S	Straat and Numb	per or Rural F	Routa Number,
to the tracetain of Attending Francisco Within 24 hours efter death.  To the Funeral Director: After this completely filled in by the funeral	Č						44				
To the Hospital or within 24 hours efter To the Funeral Director completely filled in	edicai	29a. Certifiar Certifying Phyalck	en: To the best of my kno On the basis of examina	owladga	, daath occ	curred at the t	ime, data and pla	ce, and dua to tha	cause(s) and ma	annar as stat	ted.
in 24 in 24 in Plet	8	one)	and mannar stated.	ation and	Wol ilivasii	gation, in my	opinion, daam oc	curred at the time,	date and place,	and dua to tr	na causa(s)
within 2 To the comple	Σ	29b. Signatura and titla of certifier	1001-			29c. Licen	sa number		29d. Data signa		ay, Year)
2		Yaux KN	10/0			U	4/61		Sep	SI	,00
4		30. Name and address of person who comp	lated cause of death (Item	m 23a) (	(Type, Prin	)	1	1 21			, 00 Pd 21097
		0979 K92Kh	100 100	10.	5 H	ckou	3 Red	e Rd	Coksus	Sint	70/2/043
Sta	e	31. Data filed (Month, Day, Yaar)	32. Registrar's Sign	ature	1.	1. 5	9.				
Registr	ar	OCT 0 4 2000	Denevas	1	7.	apour.	2.0				



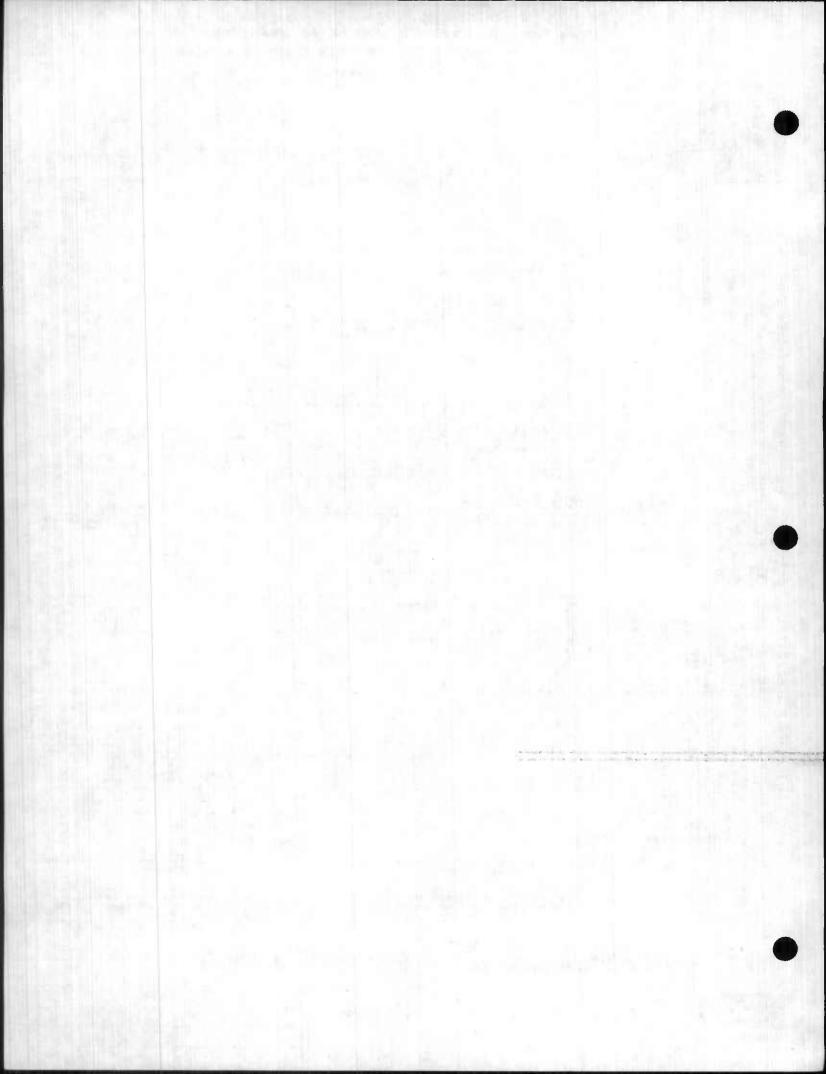
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

32859

				Cer	illicate of	Dealli		Reg. No.		
,	Physician	Decedent'a Name (First, Middle, La     Mary Jane	Rubi	n			2. Data of De Month	Day	Yaar	3. Time of Death
8,1	/Medical	, , ,		.11		41 Oh T	Octob			11:30 pm
	Examiner	4a Facility Nama (If not institution, give				4b. City, Town, or L	00-			
_		Forest Glen Skill  5. Social Security Number 6.5	Led Nursing Cer Sex 7. Age (In yrs.		If Under 1 Yaar	Silver Sp	8. Date of Bi	Montg		
	uneral rector		1□ M 2□XF 81	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, De May 4	1919	DC	lace (Stete or Foreign try)
9		Usual Residence of Decedant		Z 10						
and a	dat o	10a. State 10b. County	10c. Cit	y, Town or Loc	ation				11	0d. Inside City Limits 1 ☐ Yes 2 No
2	or 28s-f s be notified Director	Maryland Montgome	ery Silv	er Spr						**
411	D 10	10e. Street and Number			10f. Zip Code			10g. Citizen of V	vnat Coun	itry?
death with the Maryland	sher must be notified at force must be notified at Funeral Director	10012 Portland PI	Lace 12. Was Decedent Ever In U.	S. 13. W	20901	Hispanic Origin? (Sp	ecify Yes or No	USA 14. Rec	e - Americ	an Indian,
_ 1	Fur Fur	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yas 2 🛣 No			Hispanic Origin? (Sp ean, Mexican, Puarto	Rican, etc.)		k, White,	
0020 hours after	D 1	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		☐ Yes 2 1 No	Specify:		Specify	. Whi	Lte
2 2	t, the Medical Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Decede	ent's Usual Occupind of work done	pation during most of work d)	ing	16b. Kind of Bu	sinass/Ind	dustry
121	mp de	Elementary/Secondary (0-12)	College (1-4or 5+)			ld)		0 11		
d 2		17. Fathar's Name (First, Middle, Last		Homem	aker	18. Mothar's Nam	a (First, Middle	Own Hom		
lan ed be	o Be	Percy R. Rogers				Hilda Mi				
Maryland 21215-0020 d 2 should be filed within 72 hours at the and Mental Hygiene.	r other traumatic	19a. Informant's Name/Ralationship (	Type, Print)	19b. Mailing	Address (Street	and Number or Rui		er, City or Town,	Stete, Zip	Code)
E =	220	Norman N. Rubin/	Husband	10012	Portlar	nd Place,	Silver	Spring.	MD 2	20901
or te	r offer	20a. Method of Disposition	20b. P		ition (Nama of atory or other ple		Date	20c. Location -		
altimore,	ury or	1  Burial 2  Cremation 3  4  Donation 5  Othar (Special	THEIRONAL HOM State		Memorial		0/6/00	Rockvil	le, M	ID .
Salt emit	my inj	21. Signature of Funeral Service Lice	nsee	22. Fr	Name and Address I	ess of Facility Collins	Funera	1 Home.	Inc.	
w 80	240	James &	Oden							g, MD 20901
STATE OF		23a Part Enter tha disaasa, or com	plications that caused the deet one cause on each line.	h. Do not ente	r tha mode of dyi	ng, such as cardiac	or respiratory a	irrest,		Approximata Interval Between Onsat and Death
	sician edical	Immediate Cause (Final								
100	miner	disaasa or condition resulting in death)	e. Cerebrovaso							24 hours
	ě		Due to (c	r as a consequ	Jance of):					
cuted	nding physician and use as the burial-transit	Sequentially list conditions.	b Due to (o	r as e consequ	uence of):					Marie A
, °,	urial-i urial-i	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events								
ox 68760, certificate be executed	nding physical use as the bu	that initiated events resulting in death) Last	Due to (o	r as a consequ	enca of):					
ox 6	use es		d							
m a	for t	Death and a second seco			1004 (000 000 000 000		not Did	A-b		Abo annua of death 2
O. B.	been signed by the should be deteched leted by Physic	Part II. Other significant conditions of	contributing to death but not res	uiting in the un	denying causa gi	van in Perti.				the cause of death?
S, P	be det							100 123110		
of Vital Records, Physician: The law requires that	en sig						24a. Was	an autopsy omed?	ave	ara autopsy findings allable prior to
Baw r	5 N D								of	mplation of causa death?
E &	page Com						10	Yas 2 No	10	Yas 2∭ No
of Vita	entific ector, Be	25. Was case raferred to medical examinar?	Manitali		-	26. Placa of Deal	th (Check only	one)		
of hyal	this cert ral direct To B	1 Yes 2 No		ER/Outpatient	3LI DOA			idence 6 Oth		y)
	After	27. Mannar of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Dey Year)	Injury	28c. Inju	rk? ]Yas 2□No	Zou. Describe	how injury occur	60	
Division or Attending after death.	Director: I in by the ertifical	3 Suicide 6 Could not b	28e. Place of Injury - At ho	ome, farm, stre			28f. Location	Street and Numb	per or Rura	Il Routa Number,
Dis afte	al Director: After ted in by the funering Certification:	4 Homicida	building, etc. (Specif	y)			City or 10	wn, Stete)		
Hospital 24 hours		29a, Certifier  (Check only 2 Medical Exam	nysician: To the best of my kno miner: On the basis of examina	wledge, daath	occurred at the ti	ma, date and place,	and due to the	causa(s) and ma	innar as s	tated.
To the H within 24	the Funer npletely fill	ane)	and manner steted.	non and or my			TOO AT THE TIME,			
To Will		29b. Signature and title of certifier	A. H 4. 0	9 2.5	29c. Licen			29d. Date signe	d (Month,	Day, Year)
	10	4 111	Ook, mo.			2309		October	4, 2	2000
	1411	30. Name and address of person who					MD 200	201		
	State	Phillip W. Poth, 31. Date filed (Month, Dey, Year)	32. Registrar's Signa				MD 209	901	-	
- F	Registrar	OCT 0 5 2	000 Deneva	B.	pork					



#### Ple

				Ce	ertificate	e of	Death		Re	g. No.		32860		
Decedent's Neme	(First, Middle,	, Last)			11				2. Date of Death	Day	Year	3. Time of Death		
Helen	Rosha	ak							Septemb			7:20 PM		
Fecility Name (#	not institution,	give street end nu	m <i>ber</i> )				4b. City, To	wn, or L	ocation of Deeth	4c. Coun	ty of Death			
3501 For	sythia	Lane					Burt	onsv	ille	Mon	ntgome	ery		
Sociel Security Nu 04-09-945	9-9457 1□M 2⊠F 86 Y					1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, June 6,	Year) 1914		olece (State or Foreign ntry) 1sylvania		
sual Residence of			40.00	-							Т.			
a. Stete	10b. County		10c. Cit	y, Town or I	Location							10d. Inside City Limits		
aryland	Montg	omery	]	Burtor	sville	2		150				1 ☐ Yes 2X No		
e. Street and Num	ber				10f. Zip Code 10g. Citizen of Wha							nat Country?		
501 Forsy	thia L	ane			20866 United St							tates		
. Merital Status  1 Never Marrie  3 Widowed	d 2 Merrie	S. 13								American Indian, White, etc. White				
(Speci	15. Decedent's	s Education t grade completed)		16a. Dec	edent's Usua	l Occup	oatlon during mos	t of work	king	16b. Kind of	Business/In	dustry		
Elementary/Secon		College (	1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)  4or 5+)										
10				Sean	nstress	5	_			Garme				
Father's Name (i		asi)							n Petrila		ame)			
a. Informant's Na	me/Relationsh	ip (Type, Print)							ral Route Number,					
llen Barb	per/Dau	ghter		3501	l Fors	yth:	ia Lan	e Bu	urtonsvi	lle, M	D 208	66		
a. Method of Disport  1 Burial 2 4 Donation	Cremation :	3 XRemoval from ecify)	State		position (Nem rematory or of ael Chi		_		Date 2	20c. Location Jerm	yn, P			
. Signeture of Fur	eral Service L	icensee		1	22 Name and Hines—	d Addre	ess of Facility	une	ral Home	, Inc.				
un	myx	1. 80 2110	4								Sprin	g, MD 2090		
3a. Part1. Enter th shock, or hear	e disease, or o t failure. List o	complications that conly one cause on e	caused the deel each line.	h. Do not e	inter the mode	e of dyi	ng, such as	cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death		
nmediate Cause (F sease or condition sulting In deeth)		a. Resp	iratory Due to (c		romise	fr	om Lur	ng Co	ollapse			1 Month		
		Non	Small C	-2111 126		nce	r					7 Months		
equentiatly list con eny, leeding to imi use. Enter Under tuse (Disease or li	nediate tving	b. Non			equence of):	iree			The s					
at initiated events sulting in death) L			Due to (o	r es e cons	equence of):									

**Physician** /Medical Examiner Examiner

ettending physician and of for use as the burial-transit

been signed by the should be detached

After this certificata hes

To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

Physician/Medical

by

Completed

Be

0

Certification:

Medical

requires that the deeth certificate be axecuted

Box 68760.

Division of Vital Records, P.O.

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

23a. Part1. Enter the disease, shock, or heart failure. L

Immediate Cause (Finat disease or condition resulting In deeth)

1. Decedent's Neme (First, Mil

4a Fecility Name (If not Institu

3501 Forsyth: 5. Sociel Security Number

204-09-9457 Usual Residence of Decedent

10e. Street and Number 3501 Forsythia

10 17. Father's Name (First, Midd

Michael Kutch 19a. Informant's Name/Relation Ellen Barber/D 20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other 21. Signeture of Funeral Servi

10a. Stete

Maryland

11. Merital Status

Director

Funeral

by

Completed

Be

**Physician** 

/Medical

**Examiner** 

**Funeral** Director

the Meryland

permit. Peges 1 and 2 should be filed within 72 hours after death with the Merylan Department of Haaith and Mental Hygiene.
Important: If item 27 is marked other than "natural; or itema 23a or 28a-f ahow eny highry or other traumatic event, the Medical Examine must be notified at PAGE.

Baltimore, Maryland 21215-0020

Part II. Other significant cond Peptic Ulcer Disease

1 Yes 2 No 3 Probably 4 Unknown 24a

Anemia

. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
-----------------------------	--

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Menner of Death

26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work?

1 Netural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homlcide

28a. Date of Injury (Month, Day Year) 28b. Time of Injury 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

281. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes 2 No

29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signeture and title of certifier

D35996

29c. License number

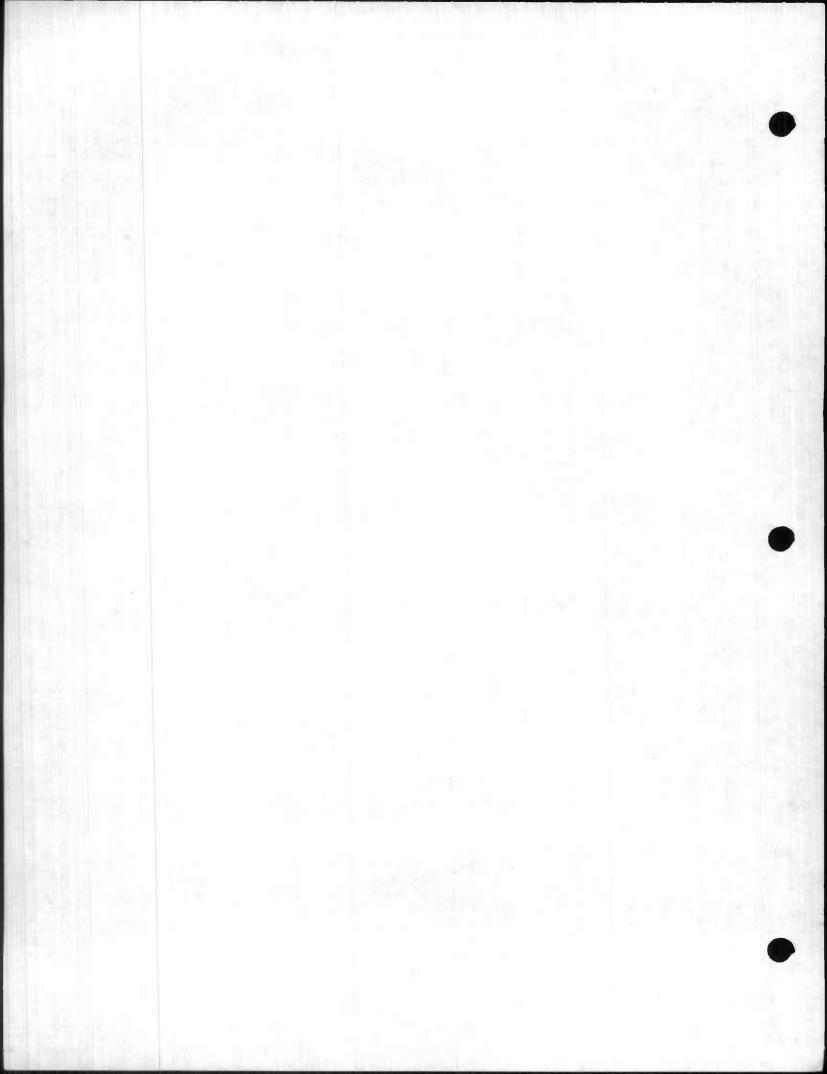
Sept. 29, 2000

30. Name and address of person who co eted cause of death (Item 23a) (Type, Print)

#400 Silver Spring, MD 20902 MD 2730 University Blvd. Linda Burrell,

State Registrar 31. Date filed (Month, Day, Year) 62 32. Registrar's Signature

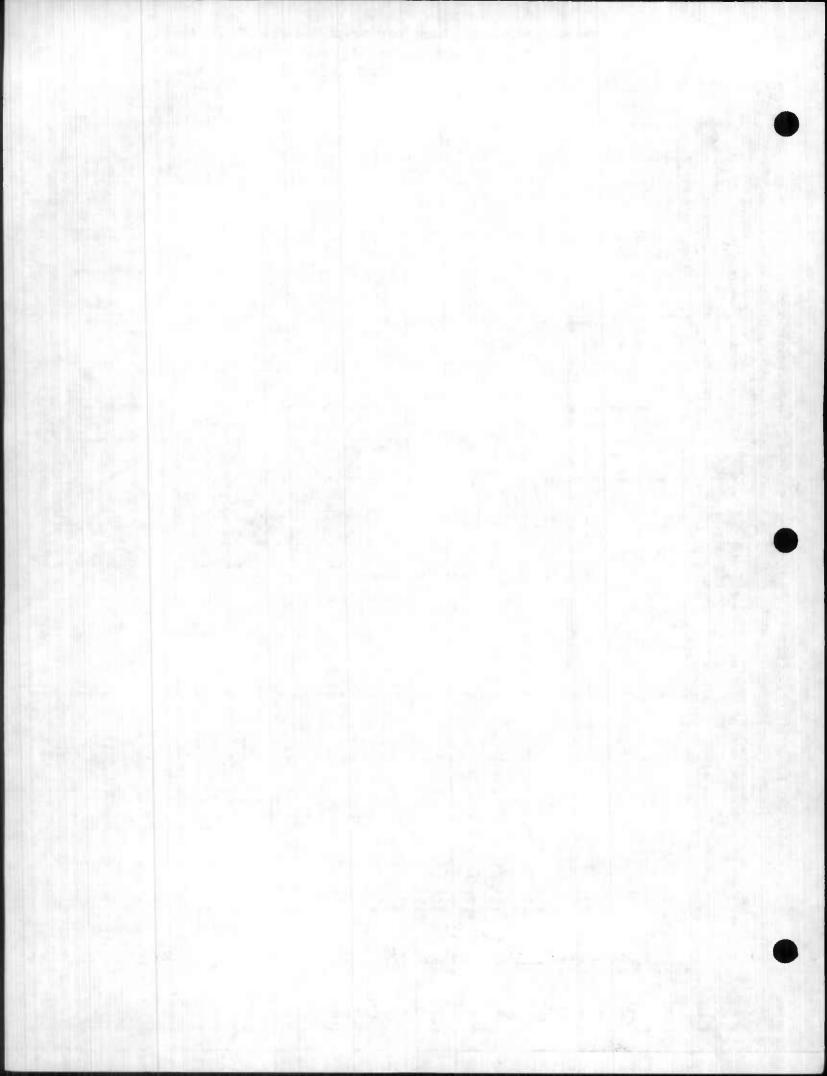
onely



State of Maryland / Department of Health and Mental Hygiene

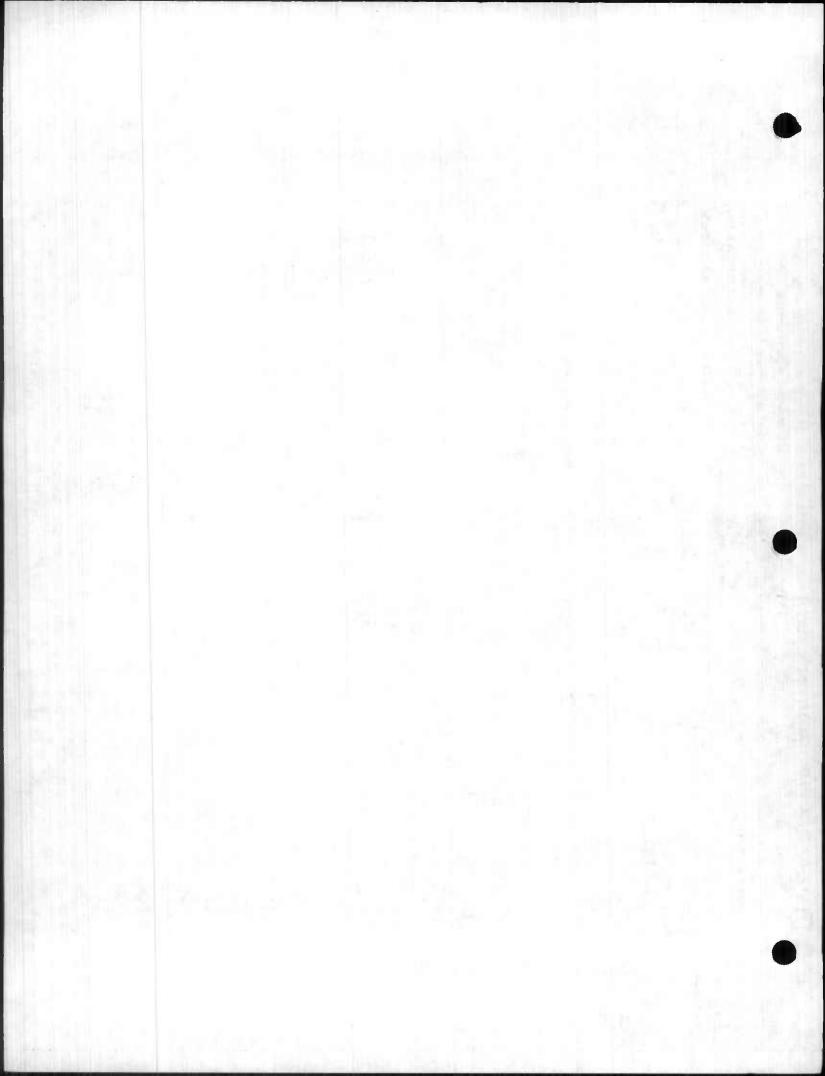
32861

					erinicate	or Death		Reg. No.		
	Dhysician	1. Decedent'a Name (First, Middle, Las	()	100			2. Date of D Month	Day	Yaar	3. Time of Death
l,	Physician /Medical	Elba Roca					Octob	er 1, 20	00	100am
	Examiner	4a Facility Nama (If not institution, give Holy Cross Hospit					or Location of Dea Spring		of Death gomer	у
	Funeral Director	5. Social Security Number 6. Se 213-76-6349	7. Age	(In yrs. last birthda 55 yrs.	(y) If Undar 1 Months E		Hrs. 8. Deta of Bi (Month, D Mar 2	nth ay. Year) 9, 1945	9. Birthple Count Boll	aca (Stata or Foraign In) Via
	p .	Usual Residence of Decedent	T							
	Marylar a-f ahow pred	MD Montgom	ery	10c. City, Town or Silver					10	0d. Inside City Limits 1 ☐ Yas 2 ☐ No
	h with the Mar 23a or 28a-1 a at be notined	10e. Street and Number 14136 Whispering	Pines Ct.	#13	10f. Zip Co 2090			10g. Citizan of V		
020	urs efter death v	11. Merital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1   Yes 2   No If Yas, Giva Yeer or Dates:	var in U,S. 13	3. Was Decedan If Yes, specify		? (Specify Yas or Nuarto Rican, atc.)  American	o- 14. Rac Blac Specify	ce - America ck, White, e	etc.
Maryland 21215-0020	s 1 and 2 should be filed within 72 hours efter death with the Maryland if Health and Mental hygiene. Item 27 is marked other than "natural", or flems 23s or 28e-7 show other treumstic event, the Medical Example ment be not additionally for the market the confidence of the Completed by Funeral Director.	15. Decedent's Ed (Specify only highast grad Elementary/Secondary (0-12)	ucation de <i>complated)</i> College (1-4or 5+	(Gi	cedent's Usual C va kind of work of DO NOT use emaker			16b. Kind of Bi Own Ho	usiness/Indi	
/land	Mental Hyginatic event, To Be Co	17. Father's Neme (First, Middle, Last) Nestor Roca				18. Mother's Sada	Name (First, Middle Salinas	e, Maiden Suman	na)	
	1 and 2 should it Health and Meni tem 27 is marked other treumatic	19a. Intormant's Name/Ralationship (7) Maria Ozeki /Daug			_		712, Silv			
Baltimore,	Page neni o nrt: If ury or	20e. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify			position (Nama ramatory or otha eake Cre	r place)	Oct 4 2000	20c. Location - Beltsv:		
Balt	permit. Page Department of Important: If any infury or	21. Signature of Funeral Service License	7604		22 Name and A Rapp F 933 Gi	ddrass of Facility uneral & st Avenue	Cremation Silver	Servic Spring,		
	Physician	23a. Part I. Enter the disease or composhock, or heart tailvia. List only of	lications that caused t ona causa on aach line	ha death. Do not a	antar tha moda o	t dying, such es car	rdiac or respiretory	arrast,	1	Approximate Interval Between Onsat and Death
	/Medical Examiner	Immediata Causa (Final disaase or condition		gkins Lym	mphoma					2 years
	è	resulting in death)	а.	oua to (or as a cons	sequance ot):	60.3				
o,	executed en and nei-transit Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	b	rua to (or es e cons	sequance of):					
ox 68760,	n certificate be executed inding physicien and use as the bunel-transit in/Medical Examir	Cause (Disease or Injury that initieted events rasulting in death) Last	c	ue to (or es e cons	equence of):					
B	the ath	De della Colonia di colonia di constanti di	ndeth, dinn de dende best		constant the analysis	a character Book!	225 DI	I tobacca use se	mtelfaute to	the cause of death?
P.O.	by the	Part II. Other significant conditions co	ntributing to death but	not rasuring in the	undarrying caus	a givan in Part I.		Yes 2 No		nably 4 Unknown
Records,	The law requires the sate hes been signed page 2 should be del						24a. Wa	s an autopsy lormed?	con	ra autopsy findings allable prior to applation of causa death?
I Re	The late he page						1	Yas 2☐No	1□	Yas 2∐No
Vital	clan: entific ector. Be	25. Was casa referred to medical examiner?	Hospital: _X			Other:	Death (Chack only			
o	hys his id	1 ☐ Yes 2 ☐ No 27. Mannar of Death	Hospital: 1 Inpatien	-		4 U NUISII	ng Homa 5 ☐ Ras	how Injury occur		9
Division	o se se	1 DNatural 5 Pending 2 Accident invastigation 3 Suicide 6 Could not be	(Month, Day	Year) Injury  y - At homa, tarm,	М	Injury at Work?  1 Yas 2 No	28f. Location	(Straet and Numi		l Routa Number,
Š		29a. Certifier 1 Certifying Phy	building, a(c.	(Specify)				own, State)	anner as st	ated.
	n 24 hound no 24 h		Iner: On the basis of a and mannar state	xamination and/or						
	To the comple	29b. Signature and life of certifier	14	Bn		icansa number		29d. Data signe	ed (Month, L	20 2000
		30. Nama and addrass of person who con Frederick G. Bar	ompleted cause of der M.D. 210	ath (Itam 23a) (Typ)	e, Print) l Park	Or., Suit	e210, Sil	ver Spr	ing	20902
	State	31. Data tiled (Month, Day, Year)	32 Registra	's Signetura	lone	Val				



			State	of Marylar	nd / Depa	artmen rtificat	t of F	lealth a Death	and M		giene	0 3	32862
2		1. Decedent's Name (First, Middle, Las	st)							2. Date of De		Year	3. Time of Death
Phys: /Me	ıcıan dical	Fidel Del Rio	373							Septem	ber 29,	2000	3:55AM
Exam	niner	4a Facility Name (If not institution, give		umber)			4	100		cation of Death	4c. Coun	y of Death	
		Suburban Hospit  5. Social Security Number 6. S		7. Aga (In yrs.	last birthday	If Undar	r 1 Year	Bethe		8. Data of Birt		gomer	
Funera Directo			M 2□ F	71	Yrs.	Months	Days	Hours	Min.	8. Data of Birt (Month, De	y, Year) 0, 1929	Spa	lace (State or Foreign try)
2		Usual Residence of Decedent								oun.	, 1,2,		
anylar show stat	-	10a. State 10b. County			ty, Town or L							1	0d. Inside City Limits
The N 28s-f	ector	Maryland Montgome	ery	Ch	evy Ch	10f. Zip	Code				10g. Citizan of	What Coun	
William William	ä	4210 East-West H	iahway				815			Sec.		What Oour	,
death Cmus 2	Funeral	11. Marital Status		cedent Ever in U	J,S. 13.	-		ispanic Ori	igin? (Spe	ecify Yas or No Rican, etc.)	Spain 14. Ra	ca - Americ ack, Whita,	
20 after or the	F	1 Nevar Married 2 Married	1 Yes	2 X No	- 10	1 X Yes				riicari, etc.)	Spec		etc.
hours If Ear	d b	3 ☐ Widowed 4 ☐ Divorced	Year or I		10a Dana	daetle Herr	al Ossue	ation	Spa	nish	16b. Kind of	Whit	
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212 d with giers r the	mo	Elemantary/Secondary (0-12)	Collega	(1-4or 5+)	Gar	dener	:				Switze		
D and the state of	Bec	17. Father's Nama (First, Middla, Last)						18. Motha	ar's Name	(First, Middle,	Maiden Suma	ma)	
yla Merita wite	2	Not Availab								Del Ri			
Maryland 21215-0020 d2 should be filed within 72 hours at this and Markall Hypines 17 his marked other than "extural", or traumetic event, the Medical Examp		19a. Informant's Name/Relationship (								al Route Numbe			
Teat Heat other 2		Avelina Del Rio/V	wile	206.	Place of Disp	osition (Nar	me of			Date	20c. Location		yland 2081 wn, State
Baltimore, semit. Pages 1 ar Oppartment of Hea mportant: if Item 2 my Injury or other		1 ☐ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		State	cemetary, cra					eptember 0,2000	Bethes	da. Ma	arvland
alti mit. partm corta	8	21. Signatore of Funeral Service Lider			2	2. Name ar	nd Addre	ss of Facili	y Rol	bert A.	Pumphr	ey Fu	neral Home
m 88.58	8	Davide.	en	1 · MOC	0803 Be	etheso	da-Cl	nevy	Chase	e, Inc.	7557 V	Viscon	sin Avenue
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that	caused the dea	th. Do not en	iter the mod	de of dyir	ng, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between
Physicia /Medica	al —	Immediate Cause (Final disease or condition rasulting in death)  Due to (or as a consequence of):											MINNTS
Examine	E	rasulting in death)											112.51
10 E B E	nine		b		J CHOM!			UMYU	מהוח	7			YEARS
60, AM be executed be executed burial-transit	Examiner	Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury		,	Oras a conse PHARYA			INDAR	L				MOMM
m - 9 80	Ical	that initiated avents	c		or as a conse	quenca of):	7.0						
Box 68 Box 68 eath certificat	Med	rasulting in death) Last			cimo	NC	UB.	smun	100	BRUX(ti)	111 /510	16811	YCANI
BOX Box ath cert for use	lan		d	THE I	Univ								
ords, P.O. Box 68 requires that the death certifical each signed by the attending phi hould be detected for use as the	Physician/Med	Part II. Other algnificant conditions of	ontributing to o	daath but not ra	sulting in tha	undarlying o	ausa giv	en in Part	l.		/	ontribute to	the cause of death
P.O. that the de by the detached	Ph	DIABERCI	MELL	LINI	ANCHI	J.				10	Yee 2 ∕ No	3 Pro	bably 4 🗆 Unknow
rds, F uiras that uiras that uiras that	d by									24a. Was	an autopsy		ere autopsy findings
3 11 6	Completed								_	perio	ormed?	00	ailable prior to mplation of cause death?
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Vital Vital The certificate irector, pag	BeC	25. Was case referred to medical examinar?		/				26. Place	e of Deat	h (Check only o	ona)		
of Vita of Vita Physician:	5	1 ☐ Yes 2 ☐ No		•	ER/Outpatie		1	4 LJ N	7	me 5 Resi			ý)
On On Galling P. Affact funeral	on	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		of tnjury nth, Day Year)	28b. Time of Injury	M	28c. tnjur Wor	yat nk? Yes 2 □		28d. Dascribe	how injury occ	urred	
Division  Oversion  or Attending siter death.  Director: Attentine J in by the fune	Certification:	2 Accident invastigation 3 Suicide 6 Could not be		a of Injury - At h	nome, farm, st			163 20		28f. Location (	Street and Nur	nber or Rure	I Route Number,
Div Direct	ert	4 Homicide datamined	build	ding, etc. (Speci	ify)		,, -,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or To	wn, State)		
Division  To the Hospital or Attending Within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	niner: On that										
within 2	×	29b. Signature and title of certifier		>		29		e number	- 1		29d. Data sign	ned (Month,	Day, Year)
0 8		· /	//				D	292.	56		09	/29	100
U		30. Name and address of person who	QUIR	use of death (Ite	m 23a) (Type	, Print) 343 /	MUN	160H	ony	AV BE			
5	State	31. Data filed (Month, Day, Year)	32.1	Registrar'a Sign	atura /	de							
Regio	strar	OCT G 2 7	nnn	Genera	1.	juju	000						

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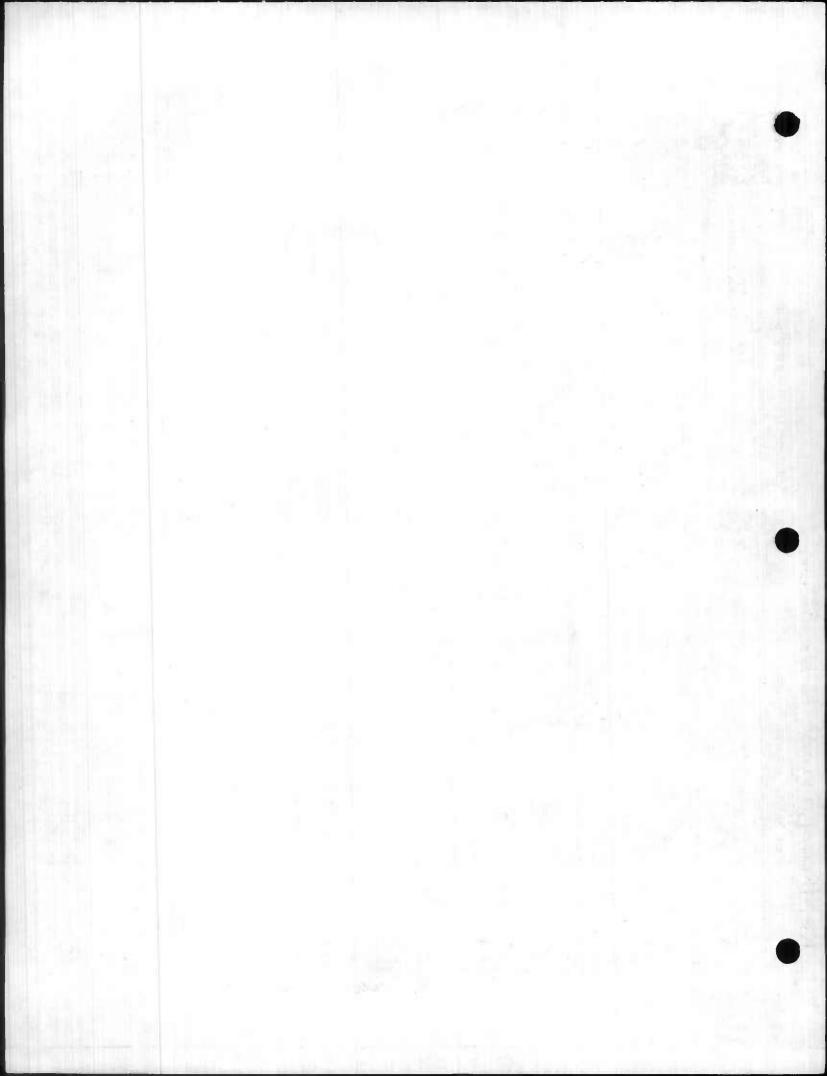


# Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 32863

			C	ertificate	of Death		Reg. No.	0 ,	02000					
	1. Decedent's Name (First, Middle, Las	st)	12 3 1			2. Date of Do		Vana	3. Time of Death					
Physician /Medical	Но	mer L. Rei	ghard			Octobe	Day er 1, 20	Year	8:50 pm					
Examiner	4a Facility Name (If not institution, giv.		8		4b. City, Tow	n, or Location of Dea		7 - 2	0.50					
	Suburb	an Hospita	1		Re	thesda	M.	ontgo	mary					
Funeral	5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthd	lay) If Under 1	Year If Under 2	4 Hrs. 8. Date of Bi	rth	9. Birtho	lace (State or Foreign					
Director	188-20-7020	MM 2□F	7.5 Yrs	Months D	Days Hours	Min. (Month, D.	1 . 1924	Coun	nsvlvania					
D	Usual Residence of Decedent		7.7			Decaibe	1, 1, 1, 2, 7	1 0111	io y z vani za					
ylan how	10a. State 10b. County		10c. City, Town o	r Location				1	Od. inside City Limits					
Ma To	Maryland Montgon	nerv		В	ethesda				1 ☐ Yas 2 ☒ No					
vith the Mai	10e. Street and Number			10f. Zip Co			10g. Citizen of V	What Coun	itry?					
h wit	10215 Hatherle	ich Drive		2	0814-222	)3	Unit	ed St	ates					
offer death v	11. Marifaf Sfatus	12. Was Decedent E	Ever in U,S.			in? (Specify Yea or No Puerto Rican, etc.)		e - Americ	an indian,					
Fu min	1 ☐ Nevar Married 2 🕅 Married	Armed Forces? 1 ⊠ Yea 2 □ N If Yes, Give	lo			Puerto Hican, etc.)		ck, White,	etc.					
(1215-0020 within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show the Medical Exercity must be notified at propriet must be notified.	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Datas:	Korea	1 □ Yes 2 ②	No Specify:		Specify	Whi	ite					
21215-0 ed within 72 ho vygiene. er than 'naturn ft, tracked	15. Decedent's Ed	lucation	16a. De	cedent's Usual C	Occupation		16b. Kind of Bu							
21215-0020 d within 72 hours at jiene. r then 'natural', or then 'natural', or then completed by I	(Specify only highest gra	da completed)  College (1-4or 5	(G	e. DO NOT use i	done during most retired)	of working								
d 212 filed with Hygiene. fther ther and, pre-	Elementary/Secondary (0-12)	5+	7	Phys	ician		U.S. G	overn	ment					
ind 2 be filed tal Hygi d other avant, b	17. Father's Nama (First, Middla, Last)					's Name (First, Middle	, Meiden Sumerr	10)						
Maryland d 2 should be file the and Mental Hy 7 is marked oth traumatic avant TO Be	David	F. Reighar	-d			Cora	Steel							
flaryland 212: 2 should be filed within end Mental hygiene. Is marked other than naumatic avent, the To Be Comp	19a. informant's Name/Relationship (			ailing Address (S	treet and Number	r or Rural Route Numl		Stete, Zio	Code)					
ore, Maryland 212 is 1 and 2 should be filed within of Health end Mental Hygiene. Itam 27 is marked other than other traumatic avent, fre To Be Comp	Barbara S. Reigha					rive Bethe								
Health Health tam 27 Hother try	20a. Method of Disposition	Id / WITE	20b. Place of Di	sposition (Nema	of	Date	20c. Location -							
Pagas ment of h	1 ☐ Buriel 2 ☐ Cremation 3 ☐		Montgom	cremetory or other	r place)	October								
altim nit. Pa ardmen ortant: injury	4 Donetion 5 Other (Specify			rium Inc		3, 2000		sda,	Maryland					
Baltimore, permit. Pagas 1 ar Department of Hea Important: if Item; any Injury or other page.	21. Signature of Funeral Service Licen	100		Robert A	Pumphi	ey Funeral Chase Inc.	L_Home/							
_ 40244	X lens 7 Keep		M00335	Bethesda Bethesda	-Chevy Maryla	ind 20814-	3507 W1	scons	in Avenue					
	23a, Part1. Enter the disease or comp shock, or heart failure. List only	plications that causad	the daath. Do not	enter the mode of	of dying, such es o	cardiac or respiratory	errest,		Approximete interval Between					
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/Medical	Immediate Cause (Final disaasa or condition	Com	10 SKIVE	hount	FRILLY	0		1	4 years					
Examiner	resulting in death)		Due to (or as e con	sequence of):	7.0000			i	Glave Glave					
P E		CANE	Due to (or as a con	2 ntory	dispo	150			GRANC					
58760, cate be assected physician end site bunal-transit	Sequentially list conditions.		Due to (or as a con		DOUGE			1.0	1					
O, axe axe axe	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.													
68760 filicate be a physician as the buri	Ceuse (Disease or injury that initiated events resulting in deeth) Lest  Dua to (or as a consequence of):													
ruffica														
Box eath cert attendin for use		d												
	Part il. Other significant conditions co	ontributing to death bu	It not resulting in th	e underiving caus	se given in Part I.	23b. Did	tobacco use co	ntribute to	o the cause of death					
the de tached tached thysi	0 10						Yes 2 No		bably 4 ☐ Unknow					
igned be dete	Renal faile	re												
Vital Records, siden: The law requires the certificate has been signe rector, page 2 should be to Be Completed by							s an autopsy	24b. W	ere autopsy findings					
The law requireta has been s page 2 should						peri	ormed?	CO	allable prior to impletion of cause deeth?					
The law in								-						
Cata ha						1	Yes 2 No	1 [	☐ Yes 2☐ No					
Of Vital I Physicien: The this certificate ral director, page 1; To Be Co	25. Was case referred to medical axaminer?	Hospital:				of Deeth (Check only	one)							
T SE E	1 Yea 20 No	Hospital: 1 Inpatie				sing Home 5 Res			y)					
	27. Manner of Death	28a. Date of Injur (Month, Day	Year) 28b. Tim	e of 28c.	linjury af Work?	1 - 1 - 1111	how injury occur	red						
Division  or Attending  ettar death.  Director: Atte d in by the fune ertification	2 Accident investigation			М	1 Yes 2 N									
Divisio	3 ☐ Suicide 6 ☐ Could not be determined	28e. Placa of Inju	iry - At home, farm, (Specify)	, street, factory, o	ffice	28f. Location City or To	(Street and Numb own, State)	er or Rura	il Route Number,					
DIVISION To the Hospital or Attention within 24 hours eiter deat To the Turneral Director: Completaly filled in by the														
Hospital 24 hours Funeral etaly filled dical Co	29a. Certifier 1 Certifying Physical Example 2 Medical Example 2	ysician: To the best o	f my knowledge, de	eeth occurred et i	the time, date end	plece, and due to the	cause(s) end ma	anner as s	tated.					
To the Hospital within 24 hours To the Funeral I completely filled  Medical Ce	one)	and manner sta		i investigation, in	my opinion, deet	n occurred at the time	, dete end place,	and due to	) (ne cause(s)					
within 2 To the complex	29b. Signature and title of perhitor	1 ,		29c. L	icense number		29d. Date signe	d (Month.)	Day, Year)					
15+1	1 to (1 ()	enningto	m) 11.	0. 1	121119	5	101	2/2	2000					
	30. Nama and address of person who	completed cause of de	eath (Item 23a) (Tv	pe, Print)			-	1						
	LOOR PONDINGH	n m	10715 5	EMINON	0 80 1	Sethesday	NO TA	817						
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Registrar	OCT 0 6 20	300 Dene	va 19.	poor	KN									

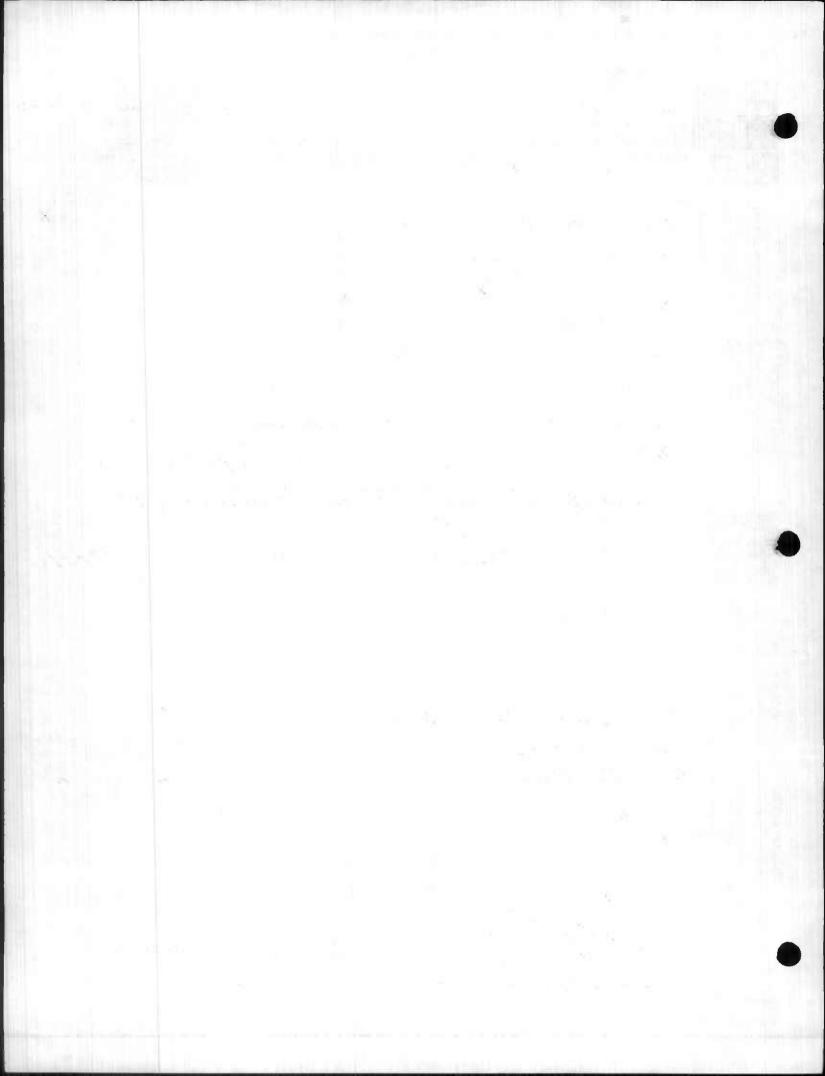
Registrar

Reighard, Homer 10/1/00



State of Maryland / Department of Health and Mental Hygiene 00 32864

					Certi	ficate of	Death		Reg. No.	0 0 2	.007
The same of		1. Decedent's Name (First, Middle, Last,	)	9				2. Date of Dec	ath		3. Time of Death
Physic /Med		Lucille Robinso	on					Month	Day 28	Year OO	8 co An
Exami		4a. Facility Name (If not institution, give	street and number)				4b. City, Town,	or Location of Death	4c. County	y of Death	7.1
		608 B. South Wes	stover D	rive			Salis	bury	Wicon	mico	
Funeral Director		134-22-2703	7. Age	(In yrs. last bii 4	triuty/	If Under 1 Yaar Months Days		Hrs. 8. Data of Birt (Month, Da Mar. 8	y, Year) 1926	9. Birthplace Country) N. Cal	e (State or Foreign rolina
and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Loca	tion	<u> </u>			104	Insida City Limits
Aeryla	5										1 ☐ Yas 2 No
28a	Directo	Maryland Wicom: 10e. Street and Number	ICO	Sali	.sbu.	10f. Zip Code		T	10g. Citizen of		
with a or		608 B South Wes	atomor D	mi		2180	1			vinat Country	r
eath E 23	era				12 Wa			(Specify Vec or No.	U.S.A	ce - American	Indian
d within 72 hours after death with the Menyland glene. In than "netural", or items 23a or 28a-f show if the Medical Examine Frust be notified at	by Funeral	1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Yaar or Dates:	0		es, specify Cut		? (Specify Yes or No- uerto Rican, etc.)	Bla Specif	ck, Whita, etc.	
72 ho	Completed	15. Decedent's Edu	cetion	16a.	Deceder	it's Usual Occu	pation	dia	16b. Kind of B	usiness/Indust	try
	ple	(Specify only highest grade Elementery/Secondery (0-12)	College (1-4or 5-	+)	life. DO	NOT use retire	during most of	working			
filed within Hygiene. ther then	00	12			Dom	estic			None	е	
	Be	17. Fathar's Nama (First, Middle, Last)					18. Mother's	Name (First, Middle,	Maiden Sumar	na)	
should be nd Mental marked o	2	Joe Davis					Dora	Davis			
d 2 should th end Mer 7 Is marke traumatic		19a. Informant's Name/Relationship (Ty	pe, Print)	19b	. Mailing	Address (Stree	t and Number of	r Rural Route Numbe	er, City or Town	, Stata, Zip Co	da)
N -		Gail Jones (Gran	ndaughte	r) $62$	Sa	ndy Dr	.Mills	boro, DE	19966		
200		20a. Mathod of Disposition  1 Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Othar (Specify)	emoval from Stata		ry, cremai	tory or other pla	.Garde	n 10/3/00	20c. Location		State
permit. Pege Depertment Important: If any Injury or		21. Signature of Funeral Service License	2/-	1	St		Funera	l Home	MA 219	9.0.1	
certificate be executed rding physician and use as the burial-transit	Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)  Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	)	Oue to (or as a o	conseque	nce of):	dovas	wlo-D	),	7	·20yus
eath ce	an		1.								
e death he etter	SIC	Part II. Other significant conditions con	tributing to death bu	t not resulting la	n the unde	erlying cause g	iven in Part I.	23b. Did t	obacco uae co	entributa to the	e cause of death?
res that the de signed by the e	by Physician/	Insclin Depender	+ Diuber	tes pr	e]1.4	201		10'	Yes 2 No	3 Probab	iy 4□ Unknown
aw requi	Completed	Atrial Fibrille							an autopsy rmed?	availal	autopsy findings ble prior to letion of ceuse lth?
The I	Con	Renal Insuffi	ency					101	res 2 No	1 □ Y	es 220No
Ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?					26. Place of	Death (Check only o	ne)		
Physician: this certific ral director,	Lo	1 Yes 2 No	lospital: 1 Inpatier	nt 2 ER/Ou	itpetlent	3 DOA	her: 4 Nursin	ng Home 5 Resid	dence 6 □Ott	ner (Specify)	
Attending or death.	Certification:	27. Menner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  6 Could not be determined	nyat ork? ]Yes 2∐No	28d. Describe to 28f. Location (Site of Town	Street and Num		oute Number,				
Hospita 4 hours Funeral	edical Cer	29a. Certifier (Check only one)		examination en				ace, and due to the occurred et the time,			
To the Vithin 2 To the Complet	Mec	29b. Signature and title of				29c. Licen	se number		29d. Date signe	ed (Month. Day	(, Year)
5 7 ¥ 5		1	1.	wo		Q2	24986	ŝ	10/2/	00	,
		30. Name and address of person who co	mpleted Suse of de	ath (Itom 23a) To Rive	(Type, Pri	e Do	B101 S	salisbury	md.	2180	1
St	ate	31. Date filed (Month, Day, Year)	32 Registra	's Signature	9	10-1					

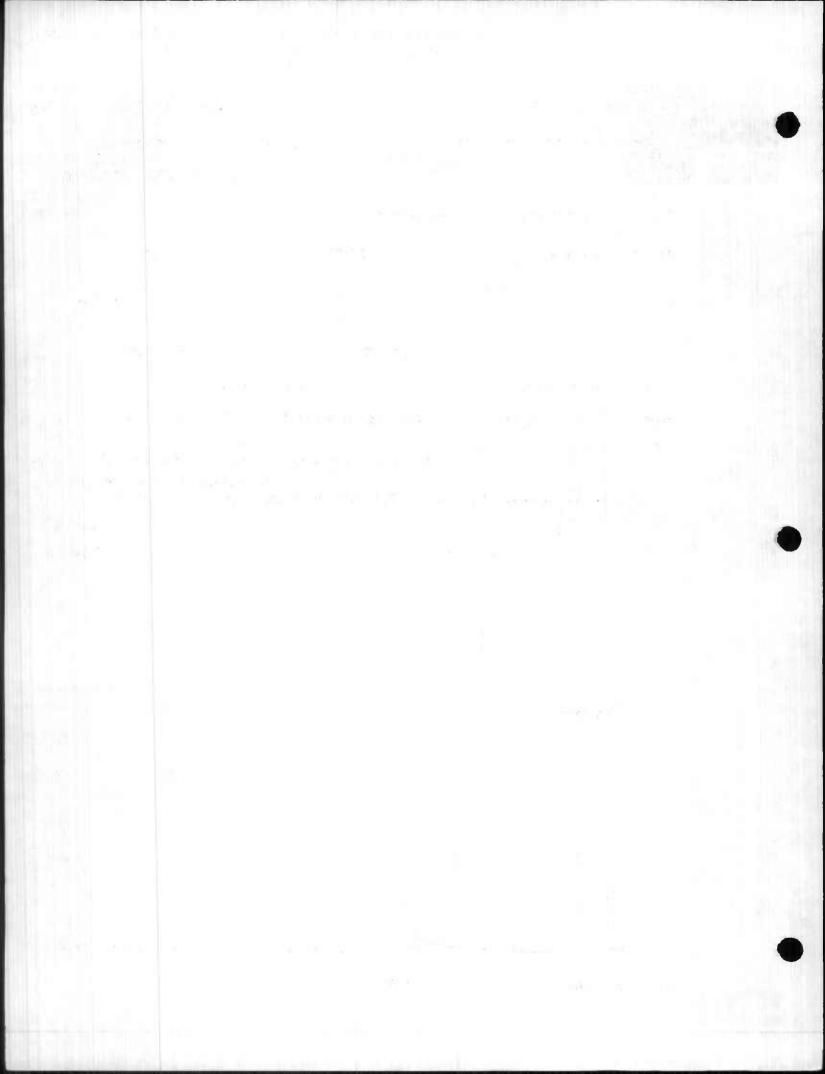


State of Maryland / Department of Health and Mental Hygiene

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miner	4e.	Fecility Nama (					on					own, or Lo	ocation of De	eth	4c. County	of Deeth	~v	
eral tor		Sociel Security N 20-24-23	lumber	6. Sex 1 ☐ M	1 11		yrs. lest t 92	oirthday) Yrs.	If Under Months	1 Year Days	If Undar Hours	24 Hrs. Min.	8. Dete of I (Month, Aug.	Birth Dey, Y	eer)		ce (Stete	or Foreign
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for must be notified at	-	MD.  Street end Nu		tgomer	Y		Kens	ingu	10f. Zip	Code				100	. Citizen of V	Whet Countr		s 2 No
Ö		3000 Mc		Avenue						895					U.S.A.		<b>,</b>	
by Funeral Director		Marital Status  1 ☐ Never Merr  3 ☒ Widowed		rried 1	/as Dece rmed For Yes Yes, Giv	2 No	r In U,S.		Ves Deced Yes, spec				ecify Yas or Rican, atc.)		14. Rec	e - Amarica ck, White, et	C.	
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	23	a. Pert1. Enter(t	De disease o	or complication	ns that or	MOO7									MD 20		Approxim	ete
u/Medical Examiner	res	eese or condition withing in death)  quentially list conv. leeding to in		a	De	Due	to (or es	e conseq									2 Wee	eks_
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y Physician	Per	t II. Other algnit	Dement		ing to de	eath but no	ot resulting	in the un	nderlying c	ause gi	ven in Part	l.			2 No	ntribute to t		e year e repetit t
Completed by	_				H								24e. W	es en a		com	eble prio plation of eth?	r to i causa
Be Com	25.	Was case refer	rad to medica	al							26 Plec	e of Deat	1 (Chack on	Yes	20XNo	10	Yes 2	CMNo
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	30.	Neme end eddr	ass of person	who complet	ted cause	e of death	(Item 23e	) (Type, F	Print)	_50		Ī		-				
State egistrar		Daphna Date filed (Mon			32. Re	egistrer's S	Signeture		oad,		aton,	MD	20902	2		_		

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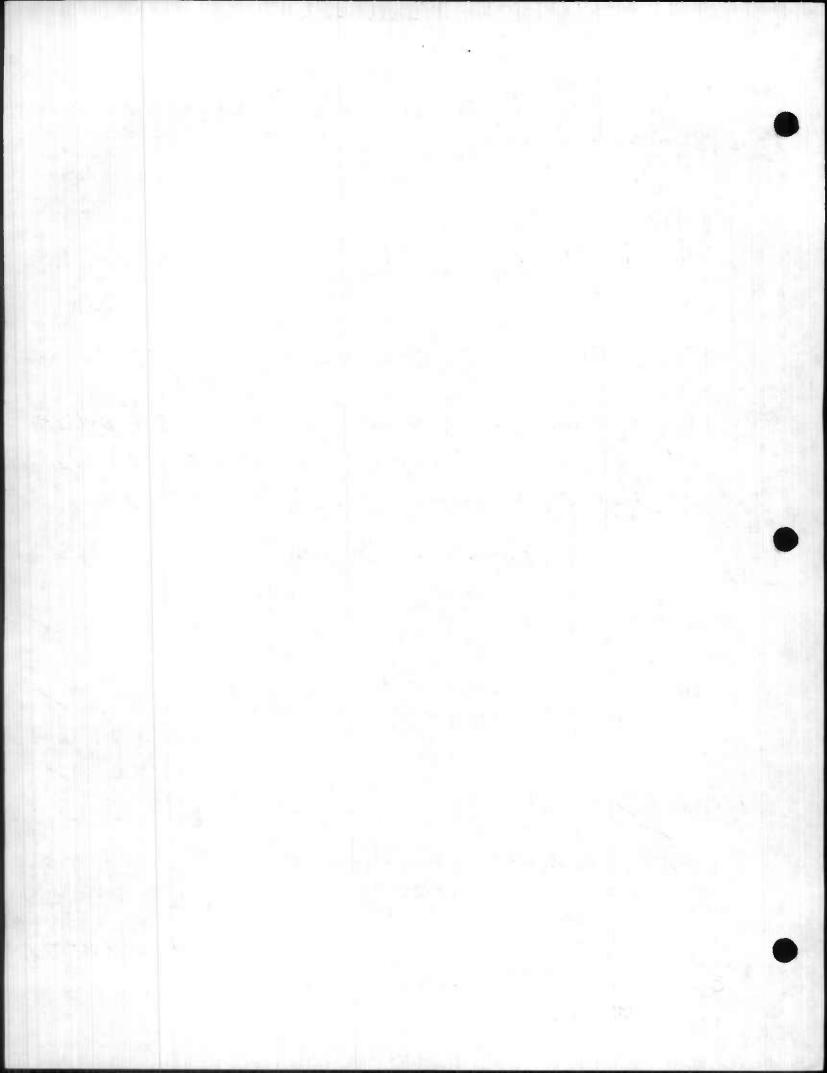


State of Maryland / Department of Health and Mental Hygiene

32866

Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** September 26,2000 2:00 PM dwara /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Wicomico Genesis ElderCare Salisbury Salisbury Center; f Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Months 12M 2DF Deys Hours 231-42 822 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director traumetic event, the Medical Examiner must be notified 23s or 28s-f 10g, Citizen of What Country? 10e Street and Number 10f. Zip Code 6 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Spacify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American I Black, White, etc. American Indien 11. Mental Stetus 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 b 1 Yes 2 No by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Edward Shrieves Elementary/Secondary (0-12) College (1-4or 5+) 0 Keen arad 0 A Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of Arieves 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Fown, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 Department of Health reportant: If Item 27 Friend ocomoke 20a Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Ellis Deartel 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) a enctar 21. Signeture of Funeral Service Licenses 22. Neme and Address of Fecility mith ennic 5 PORMOKO Homo O, Box Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be execut P.O. Box 68760, Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 3 Probably 4 Unknown á 1 ☐ Yee 2 ☐ No Division of Vital Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed' this certificate has 1 TYes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural after death. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a To the Funeral D Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

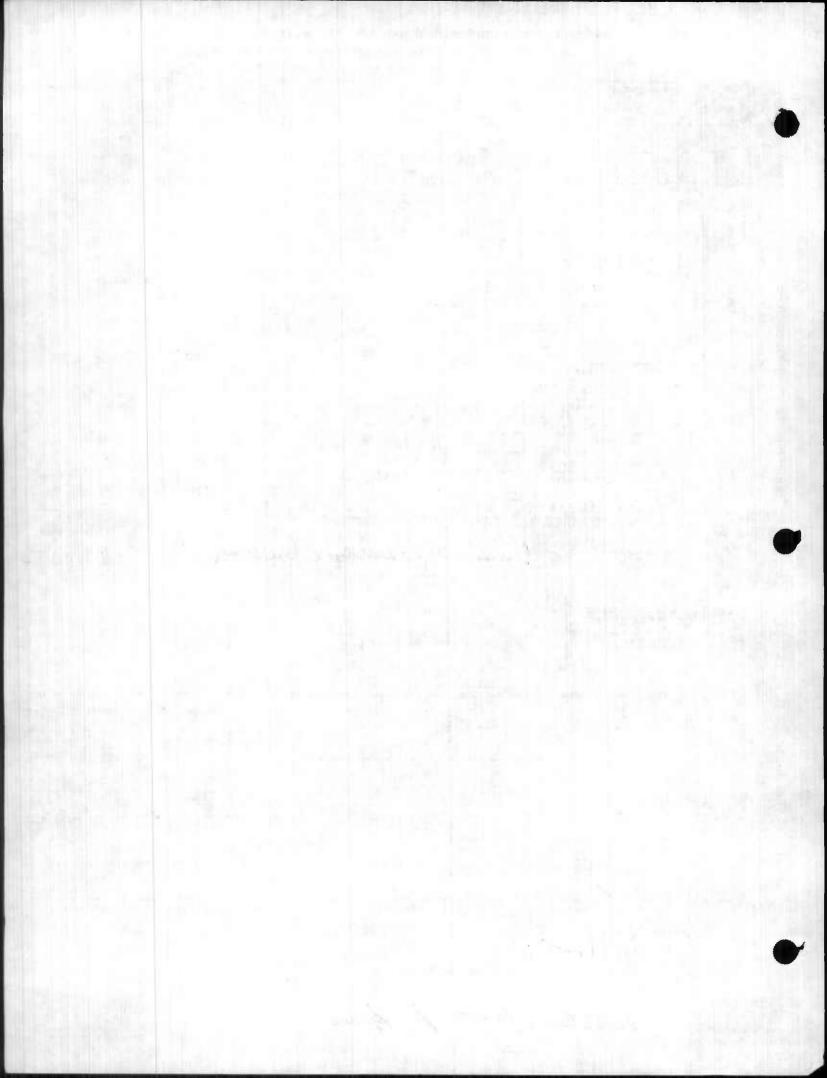
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signefure end title of D 39813 a 30. Name and address of parson who completed ceuse of death (Item 23a) (Type, Print) 5 MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD 21804 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar



State of Maryland / Department of Health and Mental Hygiene 00

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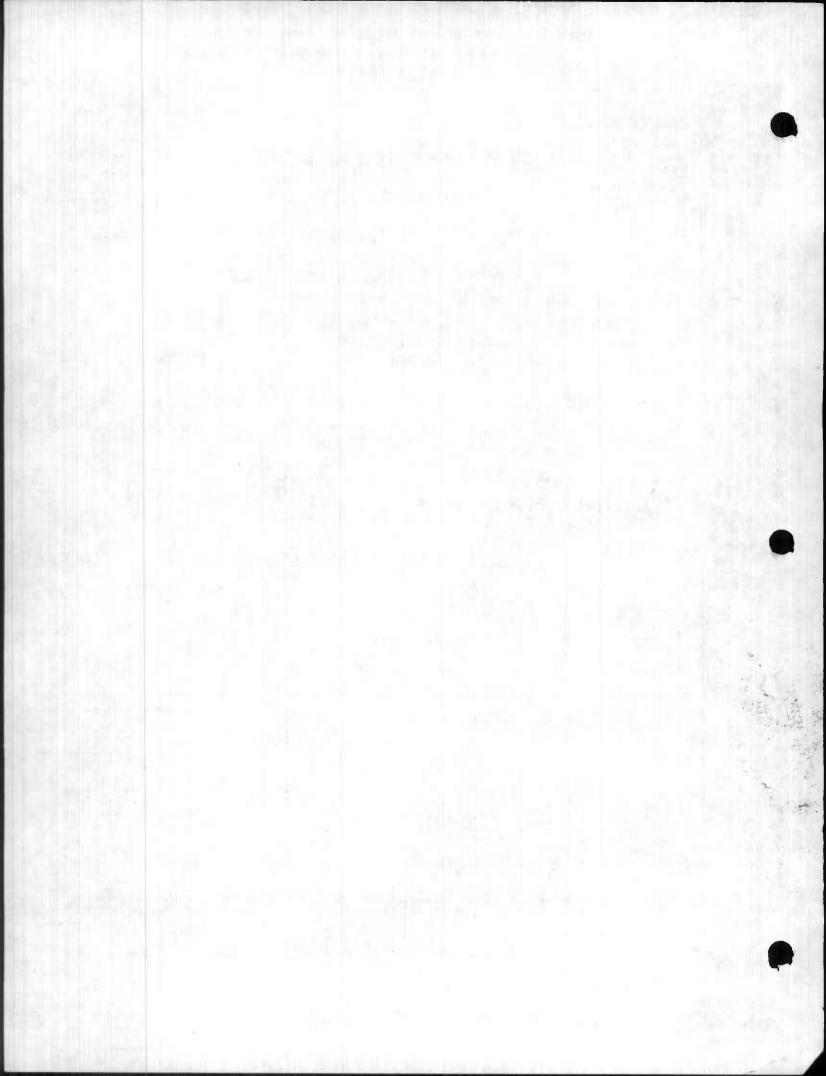
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State of Maryland / Department of Health and Mental Hygiene

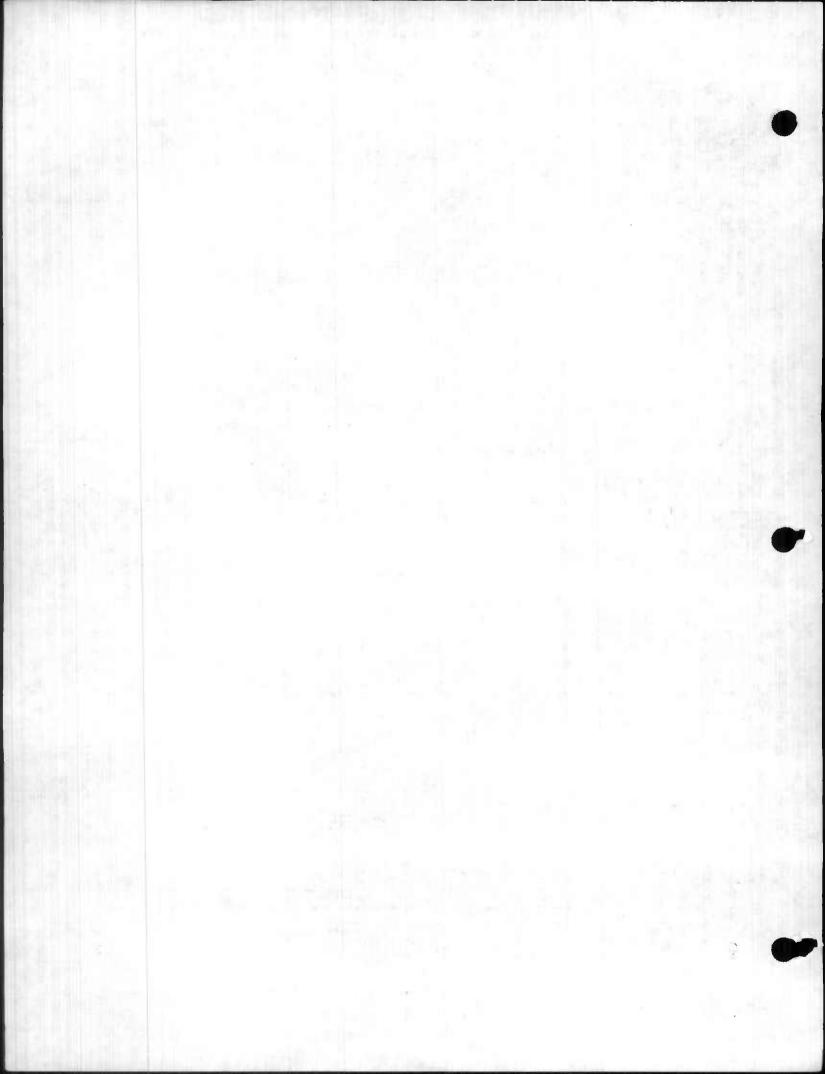
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sician edical immer disease resulting the attending physician and edical immer disease resulting the principle of the attending the action of the action of the attending the action of	Pert I. Enter the disease, or shock, or heert tailure. List diete Cause (Final	EL	caused the dec	) H		cory	Oct. 4,	2,000	Dover,	Dela	ware
hy the	se or condition ing In deeth)  entially list conditions, leeding to immediate. Enter Underlying a (Disease or injury litteled events ing in death) Last	b c	APCT Due to	(or as a cons	SCLE equence of	): KO" ):	er FAILL	DIOVASCI	ULAR DISE	ASE	YEAKS
F # E	Other aignificant condition			_		_					the cause of deat
e pe pe	CHILON	vic U	RINARY	TRAC	ETS	NFE	CITON				bably 4 Unkno
cate has been significant page 2 should be Completed									en eutopsy ormed?	ev:	ailable prior to mpletion of cause death?
				X21				10		10	☐Yes 2☐No
1 5 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	es case reterred to medical aminer?  Yes 2 No Inner of Death	Hospitel: 1 🗆	Inpatient 2 ( of Injury oth, Dey Year)	⊒ ER/Outpeti		Oth 28c. Injui	920 Nursing H	ome 5 Res	one) idence 6 Oth how injury occur		y)
rifficati	Neturel 5 Pendin investig Suicide 6 Could r determ	getion	e of Injury - At ling, etc. (Spec	home, ferm,	M	10	Yes 2 No	28f. Location ( City or To	'Street end Numb wn, Stete)	ber or Rura	il Route Number,
29a. C		g Physician: To the Examiner: On the b end men									
\$ ± 29b. S	igneture and title ot certifie	r /			25	9c. Licens	se number		29d. Dete signe	ed (Month,	Dey, Year)
		WBDG	mor hi	7	o Print'		V26:	350	10/	3/20	රට
30. Ne	me and address of person	A	se of death (Ite				St Mic	haels,	Maryland	d 216	63



State of Maryland / Department of Health and Mental Hygiene 0 0 32869

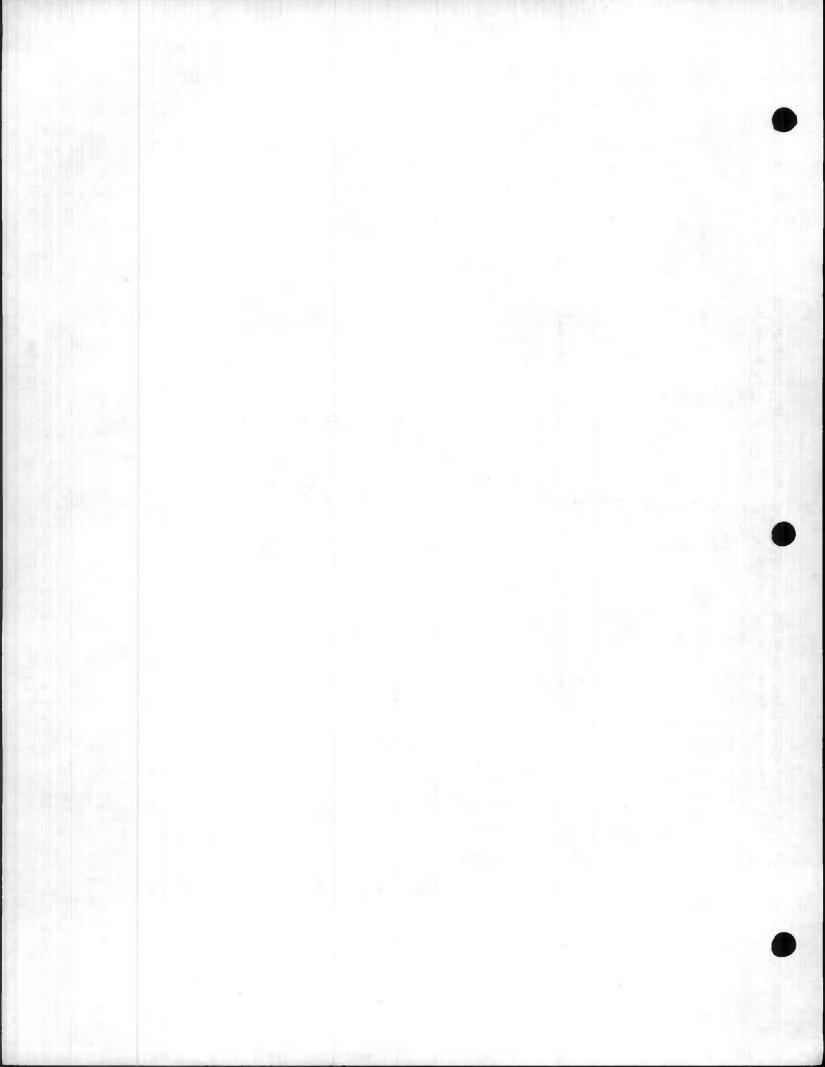
				Certii	ticate (	of De	eath			Reg. No.			
Physician /Medical	Decedent's Nama (First, Middle, L     (	ss) Catherine C	ecil St	u11					2. Data of De Month Octobe:	Day	Year OO	3. Time of Death 5:40 PM	1
Examiner	4a Facility Neme (If not institution, go Montgomery Hospice (		n Rocky	ille	410		City, Town		ocation of Deat		y of Death	v	
Funeral Director			e (In yrs. last birt	thday)	If Under 1 Y	aar If	Under 24 Hours			rth ey, Year) 1921	9. Birth	plece (State or Foreign htry) esota	
	Usuel Residence of Decedent 10a. Steta 10b. County		10c. City, Town	n or Locat	tion							10d. Inside City Limits	
otor ctor	Maryland Montgon	nery	Bethe	sda								1 ☐ Yes 2 🔀 No	
or items 23e or 23e-f show most mast be notified at Funeral Director	10e. Street and Number 7505 Democracy	Blvd., #A1	16		10f. Zip Coo	de 0817				10g. Citizen of			
Examiner must by Funeral	11. Menital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent   Armed Forces? 1 ☐ Yes, Give Yaar or Dates:	Ever in U,S.	If Yo	s Decedent es, specify Yes 2 💢	Cuben, I	anic Origi Mexican, Specify:	n? (Sp Puerto	ecify Yes or No Rican, atc.)		ack, Whita,	can Indian, etc. White	
	15. Decedent's f	Education	16e.	Deceden	nt's Usuel O	ccupatio	on	of someth		16b. Kind of I	Business/In	dustry	-
Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5	(+i		of work de NOT use re strati					Notional	Tratif	buton of Haalt	-1
o Be Co	17. Father's Name (First, Middla, Lass Everett Cect		Ad	milli:	Strat.		3. Mother!	s Nem		, Meiden Suma		tutes of Healt	_1
-	19a, Informent's Neme/Relationship		196	. Meiling /	Address (St	reet and			-	per, City or Tow	n, Stete, Zij	p Code)	
ner traus	Constance S. Qui						rive	, В	-	/irginia		015	
injury or other tr	20a. Method of Disposition  1 Burial 2 Department 3  4 Donation 5 Other (Special Control of the		20b. Piece of cemeter  Montgom	ry, cremat	tory or other	plece)	Inc.		October 5, 2000	Betheso			
any injury or	Multi Service und	usee, -	M0084	Robe 6 7557	Vame and A ert A. Wisco	ddress o Pump nsin	nrey Aven	Fune	ral Home Bethesda	/Bethesda	a-Chevy	7 Chase, Inc. 814-3501	
sician	23a. Part . Enter the disease, or co shock, or heart failure. List only	ons thet caused ause on each lie	The death. Do a	not enter t	the mode of	dying,	such es c	ardiac	or respiretory	arrest,	1	Approximate Interval Between Onset and Death	
edical Liner	Immediate Cause (Final disease or condition resulting in deeth)	a. Lung C	ancer Due to (or es e	conseque	ence of):						3	3 Months	-
as the burishtransit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	b	Due to (or as a	conseque	ence of):						1	1980	
se as the bu	Cause (Disease or Injury thet initiated events Dua to (or as e consequence of):  resulting in death) Last												
for u									1 005 014	l Andreas a series a	1	to the same of death?	
detached for u	Pert II. Other eignificant conditione Parkinson's Dise		ut not resulting li	n the unde	erlying ceus	e given	in Part I.					to the cause of death?	
should be	Cerebrovascular	Accident (	Stroke)							s an autopsy lomed?	a	Vere eutopsy findings vailable prior to ompletion of ceuse f death?	
Comp										Yes 2 No	1	☐ Yes 2☐ No	
director, page	25. Wes case referred to medical examiner?  1 Yes 2 No	Hospital:	ent 2 ER/Ou	utnationt	3□ DOA	Othor			th <i>(Check only</i>		ther (Spec	(iy) Hospice	
E = -	27. Menner of Deeth  1 XNaturel 5 Pending 2 Accident invastigati	28e. Dete of Inju (Month, Da	ry 28b.	Time of Injury		Injury at Work?				how injury occ		,,, nospiec	
al Director: After bed in by the funere Certification:	3 Suicide 6 Could not determine	be Disas of les	ury - At home, fa c. (Specify)	arm, street	t, factory, of	flice				(Street end Nur own, State)	mber or Ru	ral Route Number,	-
To the Funeral Dir completely filled in Medical Cert		hysician: To the best of the basis of the ba	examination an										
To the	29b. Signeture end title of certifier				29c. Li	icense n	umber	177	= -	29d. Date sign	ned (Month	, Day, Year)	_
8		Libre				0947	0			October	2, 2	2000	
	30. Name and address of person wh Eugene P. Libre,					enue	, Ke	nsi	ngton,	Marylar	nd 20	0895	
State	31. Dete filed (Month, Day, Year)	32. Registr	ar's Signature	4	100	1							



State of Maryland / Department of Health and Mental Hygiene

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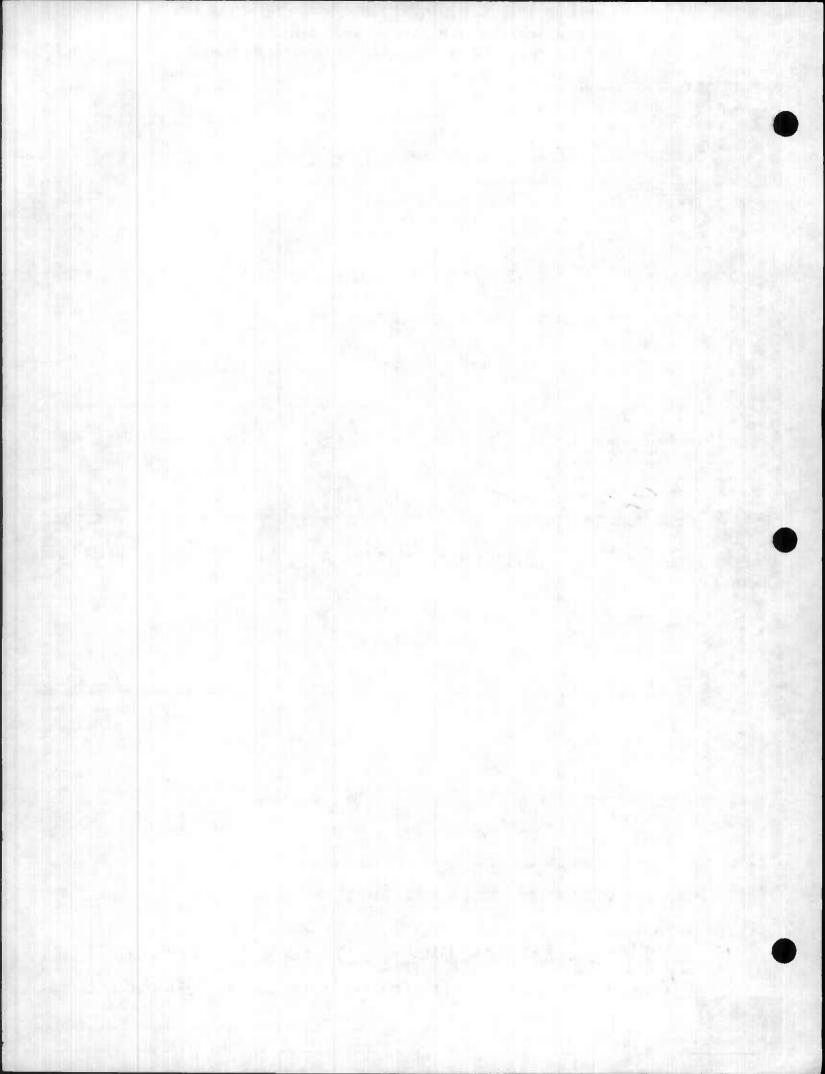
				Certif	ficate o	f Death		Reg. No.		02011
	1. Decedent's Name (First, Middle, La	est)					2. Dete of De Month	ath Dev	Year	3. Time of Death
sician ledical	Adele J. Street							er 1, 20		9:52 pm
miner	4a Facility Name (If not institution, giv	re street and number)				4b. City, Town,	or Location of Death			
	Holy Cross Hospit	tal				Silver	Spring	Monts	gomery	
eral	5. Social Security Number 6. S		ge (In yrs. last		f Under 1 Year	er If Under 24 h	in. 8. Dete of Birt (Month, De	h Year)	9. Birthpla Country	ice (Stete or Fore
tor	216-14-4369	I M 2DXF	83	Yrs.	lonins Day	110013	Oct 26	, 1916	New J	ersey
	Usual Residence of Decedent		T							
	10a. State 10b. County		10c. City, To	own or Locati	ion				100	d. Inside City Lim
ફ	Maryland Montgome	ery	Silve	r Spri	ng					1 X Yes 2 □
Director	10e. Street and Number				10f. Zip Code		3.75	10g. Citizen of	What Country	y?
=	9101 2nd Avenue				20910			USA		
Funeral Director	11. Marital Status	12. Wes Decedent Armed Forces?	Ever in U,S.	13. Wes	s Decedent o	f Hispanic Origin? Jban, Mexican, Pu	(Specify Yes or No		ce - American	
_	1 Never Married 2 Married	1 Yes 2 X				o Specify:	, , , , , , , , ,			
by	3 ☐ Widowed 4 ₺ Divorced	Year or Dates:			163 20214	o opedity.		Specii	White	te
Completed	15. Decedent's Ed (Specify only highest gra	ducation	10	6a. Decedent	t's Usual Occ	supation	working	16b. Kind of B	usiness/Indu	istry
호	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO	NOT use reti	ne during most of ( ired)		N.O.A.A	1.	
Ö	12			Clerk				Federal	Gove	rnment
9	17. Father's Name (First, Middle, Last)	)				18. Mother's N	Neme (First, Middle,	Maiden Surner	ne)	
2	Emmanuel DeCarlo					Johann	a Jamele			
	19a. Informant's Name/Relationship (	Type, Print)	1	9b. Meiling A	Address (Stre	et and Number or	Rural Route Number	er, City or Town	, Stete, Zip C	Code)
	Anthony J. Street	:/ Son		5641 C	olumbi	a Road.	#301, Col	umbia.	MD 2	1044
	20a. Method of Disposition		20b. Plece	of Disposition			Dete	20c. Location		
	1 Donation 5 Other (Specific						10/5/00	Cilman	Comin	~ MD
	21. Signature of Funeral Service Licer		Gate	-		ress of Fecility	10/5/00	STIVEL	Shrrus	g, m
<b>5</b> 000		00	0				s Funeral	Home.	Inc.	
1771	Molley	) (t. C	rle	500	Unive	rsity B1	vd., W, S	ilver S		, MD 20
	23a. Part1. Firter the disease, or com- shock, or heart failure. List only	plications that caused one cause on each ii	d the deeth. D	o not enter ti	he mode of d	ying, such es card	diac or respiretory e	rrest,		Approximete Intervel Between
n		0								Onset and Death
d	Immediate Cause (Final disease or condition	Pulmona	rv Embe	alism					1	day
r III	resulting in death)		Due to (or es		nce of):					uuy
- 6										
Examine	Sequentially list conditions.	b	Due to (or es	a consequer	nce of):					
Ä	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								1	
edical	I that initiated events	C	Due to (or es	e consequen	ice of):					
Pen	resulting in death) Last								i	
2		d							1	
10	Part II. Other significant conditions o	notributing to death h	out not resulting	n in the unde	dvina causa	niven in Pert I	23h Did	lobacco use cr	ontribute to I	the cause of de
Physician/			The trooping	g in allo direc	injing couse	given ar v en i		Yes 2□ No		bly 4 Unkr
by P							_   '0	20110	0[]11056	iny veronia
Q Q							24e. Was	an eutopsy	24b. Wer	e autopsy findin
Completed							perfo	med?	com	lable prior to pletion of cause
5									01 06	eath?
ပိ			200	-4-			10	Yes 2X No	10	Yes 2X No
8	25. Was case referred to medical examiner?						Death (Check only o	ne)		
2	1 ☐ Yes 2 🖾 No	Hospital: 1 Inpatie		Outpatient	3LI DON		g Home 5 ☐ Resid	dence 6 🗆 Ot	her (Specity)	
	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry 28t	o. Time of tnjury	28c. In	jury at lork?	28d. Describe I	now injury occu	rred	
Certification:	2 Accident investigation				M 1	Yes 2 No				
tific	3 Suicide 6 Could not be determined	28e. Place of Inj	jury - At home, c. (Specify)	ferm, street,	, fectory, offic	:0	28f. Location (S City or Tox		ber or Rural i	Route Number,
8		bullanig, or	o. (opoury)					,,		
100	29a. Certifier 1⊠ Certifying Ph	ysician: To the best	of my knowled	ige, deeth oc	curred et the	time, date end pla	ace, end due to the	cause(s) and m	enner as sta	ted.
edical	(Check only 2 Medical Exam one)	niner: On the basis of and manner str	f examinetion ated.	end/or invest	tigetion, in my	y opinion, deeth or	ccurred et the time,	date end place,	and due to t	the ceuse(s)
Σ	29b. Signature and title of certifier	00			29c. Lice	nse number		29d. Date signe	ed (Month, D.	ay, Year)
	1 Amer	6001A	2000	MAT	D 3	8262		October	2 20	200
			- COW	7 74,	1	0202		octobel	۷, ۷	000
	30. Name and address of person who									
	Anurita Mendhirat			esearc	h Blvd	., Suite	340, Roc	kville,	MD 2	20854
ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signeture	4	1.	,				
etrar	7717 - 21	ALUE AND TOWN	- 40	7 1	AT 13 12 1	F A				



State of Maryland / Department of Health and Mental Hygiene

Mental Hygiene 00 3287

							Cei	rtificate	e of l	Death			Reg. No.			
		_	1. Decedent's Nem	e (First, Middle, I	Last)		0.00			CIDA	1	2. Dete of D		Vans	3. Time of Deeth	
	Physicia	_	BELLE	HELEN S	STANLEY							Month SEPT.	29	2000	10:05 AM	
	/Medica		4e Facility Name (i			imber)			4	b. City. To		ocation of Dea		nty of Death		
1	Examine	r														
		٥,	5901 MON					If Under		ROCKV				NTGOME		
	Funeral		5. Social Security N	number 6.	Sex 1□M 2√2F	7. Age (In yrs.		Months	Days	Hours	Min.	(Month, D	ay, Year)		plece (Stete or Foreign intry)	
	Director		578-01-6			88	Yrs.				]	DEC. 1	1911	INA	AN, PA	
	2 -	-	Usuel Residence of			140-0	ity, Town or Lo							1	and to late on all to	
	thought in		10a. Stete	10b. County		100.0									10d. Inside City Limits	
	2 74	용	MD	MONTGON	ÆRY		ROCK	VILLE						}	in Yes 2 No	
	with the Maryland a or 28a-f show the notified at	Director	10e. Street and Nu	mber				10f. Zip	Code	0.100			10g. Citizen	of Whet Cou	intry?	
	uth with the Marylo 23e or 28e's sho wat be notified at		5901 MON	TOPOSE DI	. #C301				208	152			USA			
	Tre 2	Funeral	11. Meritel Stetus	VIIODE IG	12. Wes Dec	edent Ever in L	J,S. 13. \	Was Deced			gin? (Sp	ecity Yes or No Ricen, etc.)		Raca - Amen		
_	her dea iner m	5	1 Never Marr	ied 2 Married	Armed F	orces?				in, Mexican	, Puerto	Hicen, etc.)		Black, White	, etc. HITE	
22	0 0 0	Dy	3 🗔 Widowed		If Yes, Gi Year or I	ive		1 ☐ Yes 2	2 No	Specify:			Spe	cify: VVI	11.115	
ö			21	15. Decedent's			16a. Deced	font's lifeus	I Occurs	ation			16h Kind o	f Business/I	ndustry	
15	57 a 28	100	(Spec	cify only highest g			(Give	kind of wor	rk done d	during most	of work	ing				
12	E P S S	Completed	Elementery/Seco	ondary (0-12)	College (	(1-4or 5+)		. SEC		•			LAW	OFFIC	CE	
7			.12	/Films seidele se	~d)		DALL	. 010	1011		de Bloom	e (First, Middle	Afaiden Cun	namal		
Maryland 21215-0020	Sabe (	e	17. Father's Neme		51)							R. BUCH		reme)		
χ̈́	Menthe	0	LOUIS F.	MYERS												
ar	2 sho and is ma		t9a. informent's No		(Type, Print)		19b. Meilir	ng Address	(Street	end Numbe	or Au	ROCKVII	ber, City or To	wn, State, Z	ip Code)	
	and 2 nath a		MARC STAN	ILEY/SON			1002	PIPE	SIE	1 PLIAC	ا الله	MOCIVII	11111	200.		
9	十三五百 一		20e. Method of Disp				Plece of Dispo	sition (Nen	ne of ther piec	(a)		Date		on - City or T	own, State	
Baltimore,	Pages sent of mt: If the my or o			☐ Cremetion 3 5 ☐ Other (Spec		Stete	JDEAN M				S S	EPT 02	OT MIEW	MAD	VT AND	
Ē	4666	-	21. Signature of Fu		**	U	22	Name an	d Addres	ss of Facilit	v	2000		, MAR	TIMIND	
Ba	New York		N O				E	DWARD	SAC	GEL FU	JNER	AL DIR	ECTION,	INC.		
_			1		24		1	091 F	ROCKY	VILLE	PIK	E, ROCI	KVILLE,	MARY.	LAND 20852	
			23a. Part1. Enter to shock, or hea	he diseese, or co art failure. List on	mplications that	ceused the dea each line.	th. Do not ent	er the mod	e of dyin	g, such es	cerdiac	or respiratory	errest,		Approximate Intervel Between Onset and Death	
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, in the disease, or heart failure. List only one cause on each line.													
4)	/Medical		Immediate Cause disease or condition	(Finel	MI	ITIM	E/N	V411	LIN						DATUDE	
60	Examiner		resulting In deeth)	71	a. / / /	Due to	or as a consec	mence of.	y 17	3				- 11	47 (1-4	
		ē				D00101	01 45 4 00/1500	(001100 01).						1		
	Jansit Insit	Examiner			b	Due to /								- 1		
	al-tra	X	Sequentially list co if any, leeding to in	nditions, nmediete		Due to (	or as e conseq	(uerice oi).						1		
68760,			cause. Enter Under Cause (Disease or that initiated events	injury	C									1		
87	phys the	edicai	resulting in death)	Lest		Due to (	or as e conseq	uence of):						1		
×	5 04	Me			d.									1		
Bo	death c	ᇤ												1		
	the a	SIC	Pert II. Other eignif	licant conditions	contributing to d	leath but not res	sulting in the u	nderlying c	ause giv	en in Pert I		23b. Did	tobacco uea	contribute	to the cause of death?	
0.	thet the death cer ed by the attendir detached for use	Physician										10	Y00 2 N	lo 3 Pr	obably 4 Unknown	
		ò														
Records,	requires sen sign hould be											24a. Wa	s en eutopsy lormed?	24b. V	Vere autopsy findings vallable prior to	
8	v requir	Completed									_	pen	Offited	0	completion of cause of death?	
Be a	hes t	Ē											\			
8	cate he				-0-30							1	Yes 20 N	0 1	Yes 2 No	
Viitai		0	25. Wes case refer axaminer?	red to medical	14				100		of Dea	th (Check only	one)			
of	this o	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence								sidence 6 🗆	Other (Spec	oify)				
0	ing Ph h. After th funeral		27. Menner of Deet 1 Neturel	h 5 ☐ Pending	28e. Dete	of Injury oth, Dey Year)	28b. Time of	2	Bc. Injun	y et k?		28d. Describe	how injury oc	curred		
Division	ttendin deeth. ctor: Afr		2 Accident	investiget				М		Yes 2	No					
S	or Attending after deeth. Director: After in by the fune		3 Suicide	6 Could not determine	289. PIGC	e of Injury - At h	ome, farm, str	eet, factory	, office					umber or Ru	rel Route Number,	
5	after after d in b	Certification:	4 Homicide		build	ling, etc. (Speci	ry/					City or 1	own, Stete)			
	Hospital 24 hours Funeral nely filled		29a. Certifier	Certifying	Physician: To the	e best of my kno	owledge, death	occurred.	at the tin	ne, date an	d plece	end due to the	e ceuse(s) and	manner as	stated.	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai	(Check only one)	2 Medicai Ex	aminer: On the b	pasis of exemine	etion end/or in	vestigation,	In my o	pinlon, dea	th occur	red at the time	, dete end pla	ce, end dua	to the cause(s)	
	within To the comple	ž	~	title of certifier			_	290	. Licens	e number			29d. Date si	gned (Month	n, Dey, Year)	
	F3F8		1	10.00	6			-	7	701	0-	-	Can		20	
	15		The	mey 4.	1300	Lou, V	WW		1)(	ノナン	87		X 14	MBER	24,2000	
	1		30. Himp and eddr	ess of person wh	o completed ceu	se of death fite	m 23e) (Type,	Print)	^	,	1		0		111/2 - 2 = 2	
		1	Brus	N.B	Sown,	MD 9	707/4	EDICE	nli	ENTE	RD	elve !	NOCKU	46/	ND 40820	
	State	,	31. Date filed (Mon	th, Dey, Year)	32.	Registrer's Sign	ature	-	-		1	1		1		
			1	E il I:B	ATION A	Buckey	19	RA	30 MA	7						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Day Physician September 25, 2000 8:30PM Louise B. Sprinkle /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mariner Health Care of Bethesda Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1 M 2 XF Yrs. 251-18-4052 Director July 6, 1918 North Carolina Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Madical Examiner must be notified at 1 X Yas 2 No Director Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7104 Meadow Lane 20815 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, Black, White, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 ŽNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify p 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry e filed within al Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If Nem 27 is marked oth eny injury or other traumatic event page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be 10 James O. Belton Mary Jane Hawks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Charles Duke Brannock/Son 7104 Meadow Lane, Chevy Chase, Maryland 20815 20b. Place of Disposition (Nama of cematary, crematory or other place) 20n. Method of Disposition Date 20c. Location - City or Town, Stata 1 ID Burial 2 ☐ Cremation 3 ☐ Removal from State Sept 30 North Carolina 4 Donation 5 Other (Specify) Oak Grove Cemetery Mt. Airy, 2000 Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 75

Bethesda, Maryland 20814-3501

23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. 7557 Wisconsin Ave. Approximata Interval Between Onset and Death Physician /Medical tmmediate Cause (Final disease or condition resulting in death) Respiratory Arrest 5-10 Minutes Examiner Dua to (or as a consequence of): Examiner Recurrent Aspiration Pneumonia 6 Months physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Chronic Obstructive Pulmonary Disease Years Physician/Medical Dua to (or as a consequence of): for use as P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☑ Yaa 2 ☐ No 3 ☐ Probably 4 ☐ Unknown The lew requires that Records, by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed paga 2 s 1 ☐ Yes 2 ☒ No 1 Yes 2 No Division of Vital Attending Physician: 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 XNursing Homa 5 Aesidence 6 Othar (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 (XNatural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun. investigation 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as staled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and placa, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of contiller 29d. Data signed (Month, Day, Year) 29c. License number D19609 September 26, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 Darnestown Road, #202, Gaithersburg, MD Raman R. Tuli. M.D. 31. Data filed (Month, Day, Year) 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

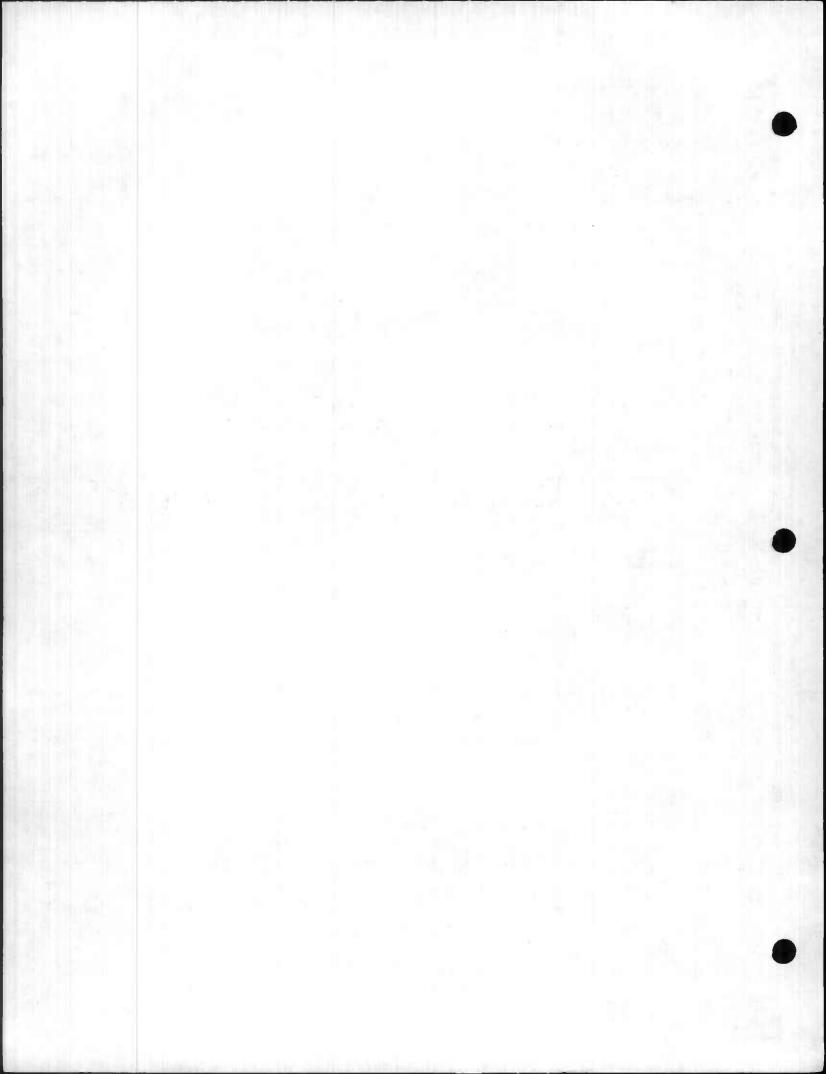
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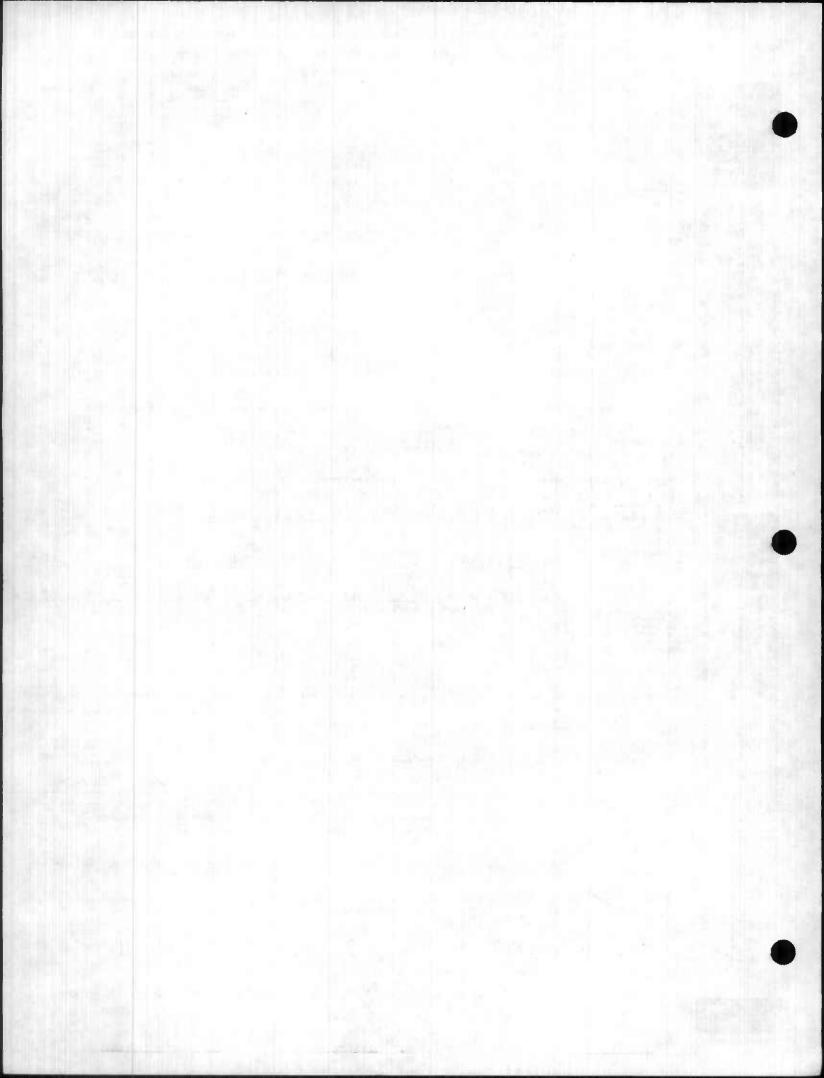
State of Maryland / Department of Health and Mental Hygiene 32873

Certificate of Death

			Dealli		Reg. No.						
Physician	Decedent's Neme (First, Middle, L     Lois Douglas Wea		2. Dete of D Month Octobe	Day	3. Tima of Death						
/Medical Examiner	4a Facility Name (If not Institution, gi			-	4b. City, Town,	or Location of Dea			1020		
LAdminer	Suburban Hospit	21				Bethes	da	Mont	Omer		
Funeral			In yrs. last birthde	y) If Under 1		If Under 24 i	irs. 8 Date of B	irth		place (State or Foreintry)	
Director	215-12-9513	1□M 2\ F	A 2 F 84 Yrs. Months Day			Hours N	lin. (Month, D			country) lichigan	
	Usual Residence of Decedent		04			1	July	, 1710	1110	nigan	
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flar death with the Menyland Flams 23s or 28s-1 show shar mast be notified at Funeral Director	Maryland Montgon	nerv	Rockvil	1e						t□Yes 2∏	
	10e. Street and Number	,	10f. Zip Code				-11-2-1	10g. Citizen of 1	ntry?		
	11505 Farmland I	)rive	Was Decedent Ever in U.S. 13. Was Decedent of					Ti-dead (			
	11. Marital Status	12. Was Decedent Ev				lispenic Origin?	(Specify Yes or N	United 1	S ndien,		
	1 Never Married 2 Married	Armed Forces?					ierto Ricen, etc.)	Ble	Bleck, White, etc.		
0 5	3℃ Widowed 4 Divorced	If Yes Give 1 Yes 2 No Specify:								ite	
'natural',	15. Decedent's E	ducetion	16a. De	cedent's Usuel	Occup	etion		16b. Kind of B			
	(Specify only highest gi	rade completed)	(Gi	ve kind of work	k done	during most of	working	Nation			
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other vent, be Co	17. Father's Name (First, Middle, Las	2 Administrative Assis						e, Maiden Suman			
avant Be											
marked of umatic ave								Douglas	O	0-40	
bue c	19e. Interment's Name/Relationship				,						
Heeith am 27 I other tri	James W. Spinks/	Son				k Road,	#8, Seal	-			
0 = 1	20a. Method of Disposition	☐Removel from State	20b. Plece of Dis cemetery, o	rematory or of	e or her plac	ce)	Oct 6	20c. Location	- City or To	own, Stete	
ortant: If its injury or o	4 □ Donetion 5 □ Other (Spec		Montgomery				2000	Bethesd			
Department Important: I any injury o pncs.	21. Stonature of Funeral Service Lice	see		22. Name end	Addre	ss of Fecility	Robert A.	Pumphr	ey Fu	neral Ho	
ded in a	1 Vile	3					ase, Inc.		Wisco	nsin Ave	
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,									Approximate	
nysician	shock, or heert tailure. List only	y one ceuse on each line							i	Interval Between Onset and Deeth	
Medical	immediate Couse (Final disease or condition resulting in death)  a. Irreversible Congestive heart failure  Due to (or as a consequence of):  Arterios cleratic Cardio Vascular disease										
xaminer	disease or condition resulting in deeth)	" TALEN	ersive	Condo	STIL	re near	Tailme	,		2 Mon 14	
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in and tal-transit Examiner		b. Arteri	DSCRETOTIC		dio	Va Scula	r dise	ise	10	several 45	
physician and s the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Di	ue to (or es e cons	sequence ot):					1		
buria	Cause (Diseese or injury	c									
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ding p	d.										
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igned by the attented for up detached for up by Physician	Pert II. Other significant conditions	ert II. Other significant conditions contributing to death but not resulting in the underly						23b. Did tobacco use contribute to the ca			
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igned by Pt											
sate hes been sign page 2 should be Completed by								s an autopsy formed?	91	ere eutopsy findin vailable prior to	
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page 2							10	Yes 2000	1	Yes 2 No	
certificata irector, pag	25. Wes case reterred to medical					26. Piece of	Deeth (Check only	one)			
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or this certific eral director. n: To Be	27. Mennes of Deeth	28a. Dete of Injury 28b. Time of 28c. Injury et					-	ome 5 Residence 6 Other (Specify)  28d. Describe how Injury occurred			
within 24 hours after death.  To the Funeral Director. After this completely filled in by the funeral di Medical Certification: To	1 Neturel 5 ☐ Pending 2 ☐ Accident Investigetic		(ear) Injur	M		rk?  Yes 2 □ No		28t. Location (Street and Number or Rural Route Number,			
otor y the	3 Sulcide 6 Could not	be See Place of Injury	- At home, tarm.	street, tactory.	office						
rs after death.  al Director: After to in by the funeral Certification:	4 Homicide				own, State)						
Fille C	29a. Certifier 1 Certifying P	hypician: To the heat of	ny knowladaa da	ath accuract a	t the ti-	me date and al	ace and due to th	e cause(s) and m	anner so	risted	
n 24 hound the Funer pletely file		miner: On the basis of e	xamination and/or	Investigation,	in my c	opinion, death o	ccurred at the time	e, date and place,	and due	o the cause(s)	
within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7		end menner stete	u.	200	Linane	e number		29d Date sign	d (Month	Day Year)	
¥ 1 8	29b. Signature and title of certifier D2339						111 / / / / /				
12	gum Lwin	James EW Month MD D:						October	17, a	(000	
	30. Name end eddress of person who	completed cause of dee			(	) 1,	ockville,				
	James E. IN	ilsen Jr. W.D	11125	Rockvill	ct	ike K	Dehville	Movulou	20	20852	
State	31. Dete filed (Month, Day, Year)	32. Registrer		The state of the		, all	DOWN ILE	infra dura	- V		

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death Physician E. SMITH 11 Am 4b. City, Town, or Location of Death 4c. County of Death /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Maris Hospice-Mercy Stella Boutimore
If Under 24 Hrs. 8. Date of Baltimore If Under 1 Year . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 M 2 F 237 - 34-7614 Usual Residance of Decedent April 01, 1924 North Carolina Director with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show the Medical Examiner must be notified at 1 XYas 2 □ No Baltimore Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Street #1110 21201 United Funeral onway 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Whita, atc. 11. Marital Status filed withIn 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates: 1 Never Married 2 Married 0 Maryland 21215-0020 1 ☐ Yes 2 No specify: White þ 3 ₩ Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ollector insurance 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Nama (First, Middla, Last) and Mental ! Pages 1 and 2 should be Smith Alexander Truberger 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 818 Church Street nt of Health and His His Health hings Mountain, NC Brother Robert Smith Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata permit. Page Department of Important: If eny Injury or page. Gift Foundation 10-02-00 4 Donation 5 ☐ Other (Specify) Laurel, Maryland 22. Name and Address of Facility Anatomic Gift Foundation 21. Signatura of Funeral Sarvice License 7 Laurel 13948 Baltimore Avenue mo 2010 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each line. Approximate intervat Between Onsat and Death Physician tmmediate Causa (Finat disease or condition resulting in daath) /Medical 1 yew ance Examiner De to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be execu P.O. Box 68760, Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Was casa rafarred to medicel 26. Place of Daath (Check only one) Hospital: Othar: 4 Nursing Homa 5 Residence 6 Nother (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of tnjury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be determined 3 Suicida 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a Certifie 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licensa number 29d. Data signed (Month, Day, Year) MD 038675 10 2 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) MESHU LAM 301 12 SVITE 605 BALTIMORE MD 21202 PAUL

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State

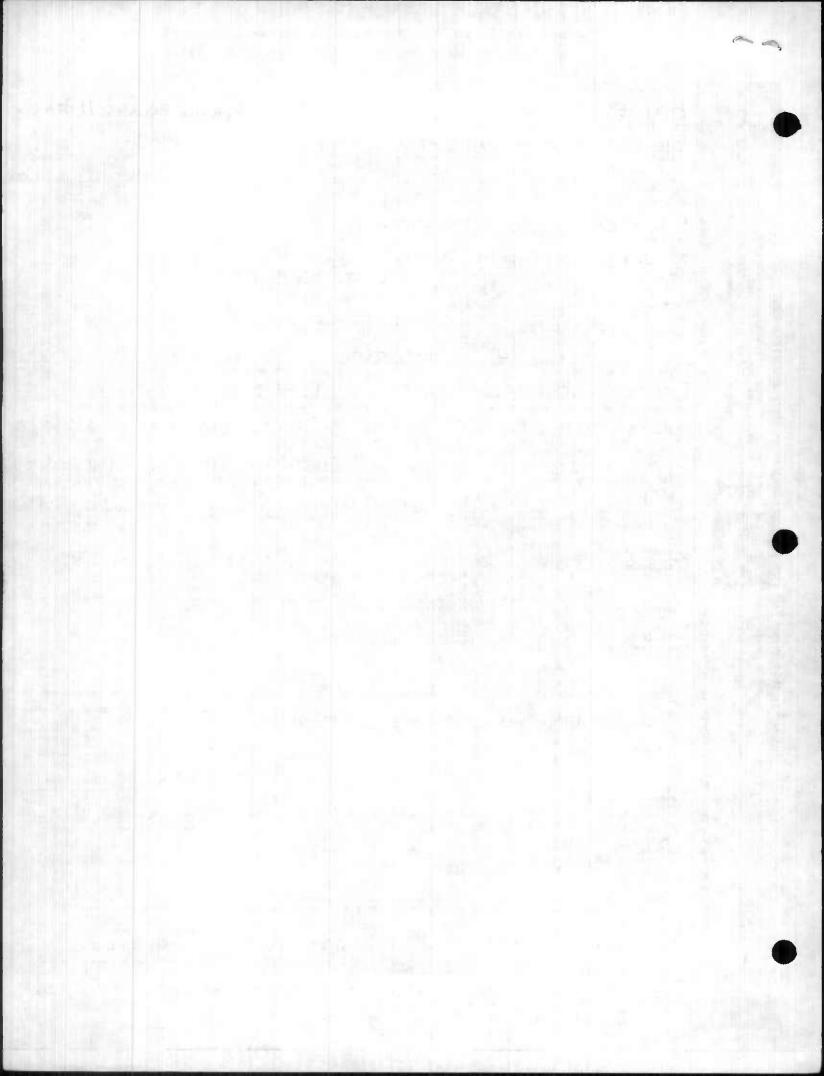
Registrar

31. Data filed (Month, Day, Year)

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32. Registrar's Signatura

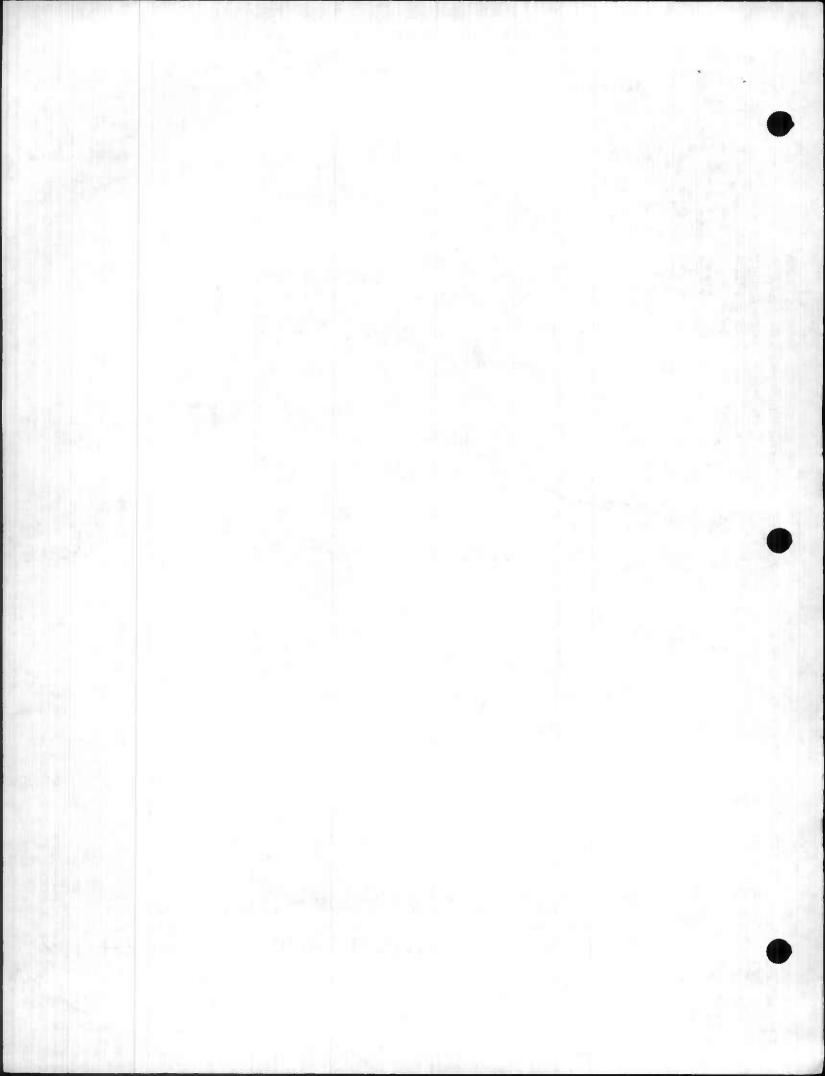
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State of Maryland / Department of Health and Mental Hygiene 0 0 32875

Certificate of Death

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Physician	1. Decedent's Name (First, Mic	idie, Last)						2. Date of De Month	Day	Year	3. Tima of Death			
/Medical	SHERYL SHERMAN OCTOBER 3, 2000 5:30 PM													
Examiner	4a Facility Nama (# not institut	ion, giva street and n	um <i>ber)</i>			4b. City, To	wn, or Lo	ocation of Deat	h 4c. Cou	inty of Death				
	BEDFORD COURT	NURSING H	OME			SILV	ER S	PRING	MON	VIGOME!	RY			
Funeral	5. Social Security Number	6. Sex	7. Aga (In yrs.	last birthday)	If Undar 1 Year Months Days		24 Hrs. Min.	8. Data of Bir (Month, Da	th Year)	9. Birth	placa (Stata or Foraign			
Director	272-10-1679	1□ M 2∏F	88	88 Yrs. Months D			EVIIII.	06-12-	-1912 OHIC		iniy)			
D	Usual Rasidence of Decedent													
ylan	10a. Stata 10b. County 10c. City, Town or Location										10d. Inside City Limits			
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or 28a-f s or 28a-f s or coding	10a. Sfreet and Number				10f. Zip Coda				10g. Citizan	of What Cou	ntry?			
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be filed tel Hygid d other event, II	17. Father's Nama (First, Middle	a, Last)						a (First, Middla		nama)				
Mentel Mentel	BENJAMIN DOLIN	NSKY				ANN	NA KOBITZINK							
N Pu	19a. Informant's Name/Ralatio	nship (Type, Print)		19b. Mailie	ng Addrass (Stree	and Numb	er or Run	al Routa Numb	ar, City or To	wn, Stata, Zi	p Coda)			
27 In	AILEEN GOLDMAN	1/DAUGHTER		17024	4 CASHELI	L ROAD	, RC	CKVILLE	E. MARY	LAND	20853-1013			
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olume it	21. Signature of Funaral Sarvio	***************************************	MT		E CEMETE   2. Nama and Addr		da e	2000 SOLON, OHIO						
Depentir. P Depentir Importar any Injur	21. Signature of Furnaral Salvin	INC.												
4010	EDWARD SAGEL FUNERAL DIRECTION, INC.  1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 2085													
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ving physician and use as the burial-transit	Sequentially list conditions,	0.	Dua to (d	or as a consac	quance of):									
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After the funeral fune									how injury oc	curred				
Attending or death.  octor: Afte by the func	2 Accidant inva	M 1 Vee								as 2 No				
or Attendi after death Director: A I in by the f ertificati	3 Suicida 6 Cou data	mined 288. Plac	ot be ned 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28							ımber or Rur	ral Routa Number,			
tal or Attending P Ins after death.  al Director: After t led in by the funers  Certification:			omig, ato. (opcom	,,					wn, Stata)					
hour hour hour hy fill hy		ing Physician: To th												
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 7	(Check only 2 Medic	of Examiner: On tha l and ma	basis of axamina nnar statad.	ition and/or in	vastigation, in my	opinion, das	ath occur	red at tha tima,	data and pla-	ce, and dua	to the cause(s)			
Vithir Somy	29b. Signature and title of certifies 29d. Data signed (Mo									gned (Month	, Day, Year)			
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Registrar	0010	A 5000	7	10.	10000									



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #7,10/5/2000, BMW, Montg.Co. 1. Decedent's Nama (First, Middle, Last) 3. Tima of Death 2. Date of Deeth September 30, 2000 **Physician** LAWFORD SHAW 2053 /Medical Ac County of Death Prince Georges 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Dete of Birth JUNE Dear) 1919 SAMAICA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 267-52-7038 10/M 20 F 81Yrs Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show Y Yes 2 No MD MONTGOMERY SILVER SPRING Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 11814 IDLEWOOD ROAD 20906 USA Funeral filed within 72 hours after deeth Hems ; 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14 Race - American Indian than "naturel", or item the Medical Exeminer Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Hyglene. FARMER N/A Pages 1 and 2 should be filed vinent of Health and Mental Hygient; if hem 27 is marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be MATILDA BARNETT SAMUEL SHAW 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) FESTUS SHAW (SON) 11814 IDLEWOOD RD. SILVER SPRING, MD. 20906 Hem 2. 20e. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete FAMILY 1 Burial 2 □ Cremation 3 □ Removal from State MADRAS ant: If I PLOT. 10/14/00ST. ANNS, JAMAICA b 4 ☐ Donetion 5 ☐ Other (Specify) AUSTINACTO STER FUNERAL HOME 21. Signature of Fugeral Service License P L 3821 14TH ST. N.W. WASH, DC. 20011 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, that only one cause on each line. Approximate Intervet Between Onset end Deeth Physician Arterioscherotic Cardioviscular Discase /Medical mediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events rasulting in death) Lest Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 8 for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed by 24b. Were eutopsy tindings eveilable prior to completion of cause of death? 24a. Was en eutopsy performed? page 2 1 Yes 27 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case reterred to medicat Be 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2E/ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. tnjury at Work? Affer 5 Pending investigation 1- Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3

or Attending Physician: The law requires that the death certificate be executed Box 68760. Division of Vitai Records, P.O. To the Hospital or Attendit within 24 hours after death. To the Funerel Director: A

21215-0020

Baltimore, Maryland

completely

filled in

State Registrar 4 Homicide

(Check only one)

29a. Certifier

29b. Signature and title of certifier

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OCT

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

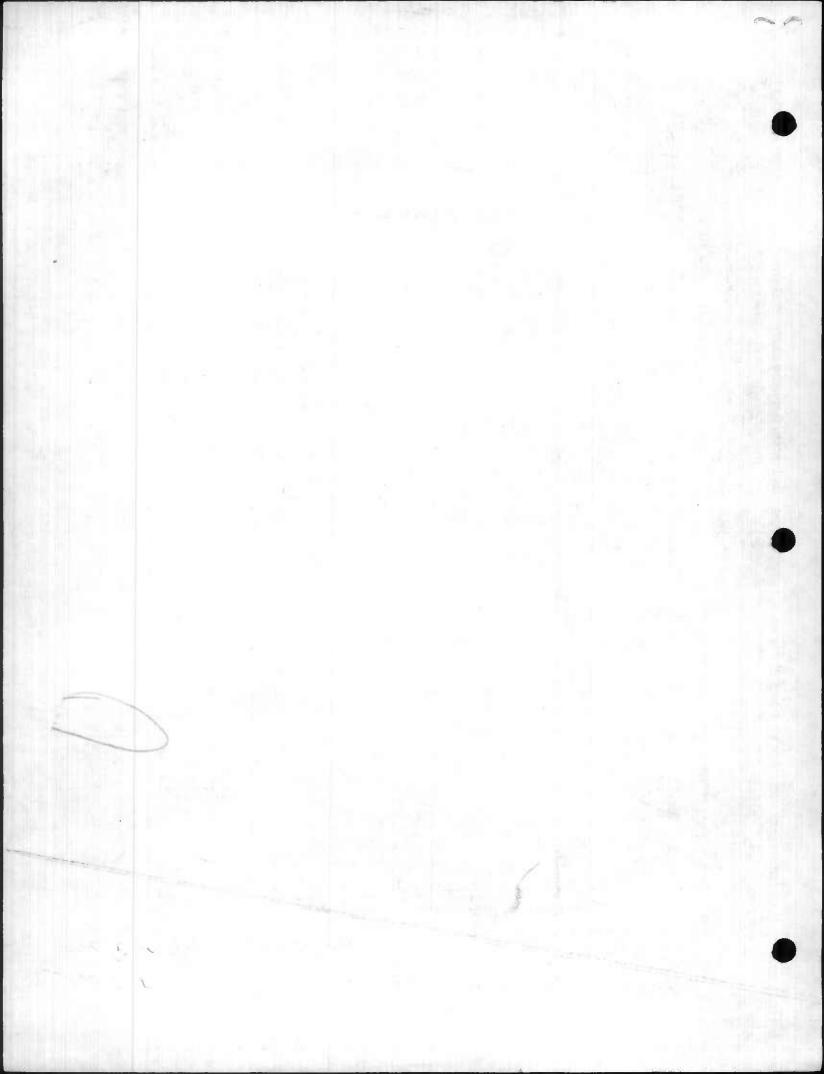
\*\*Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cheverly, Manyland 20785 Sulveter, 300, Has pital Drive 31. Dete filed (Month, Dey, Year)

Jener

32. Degistrar's Signature 2000



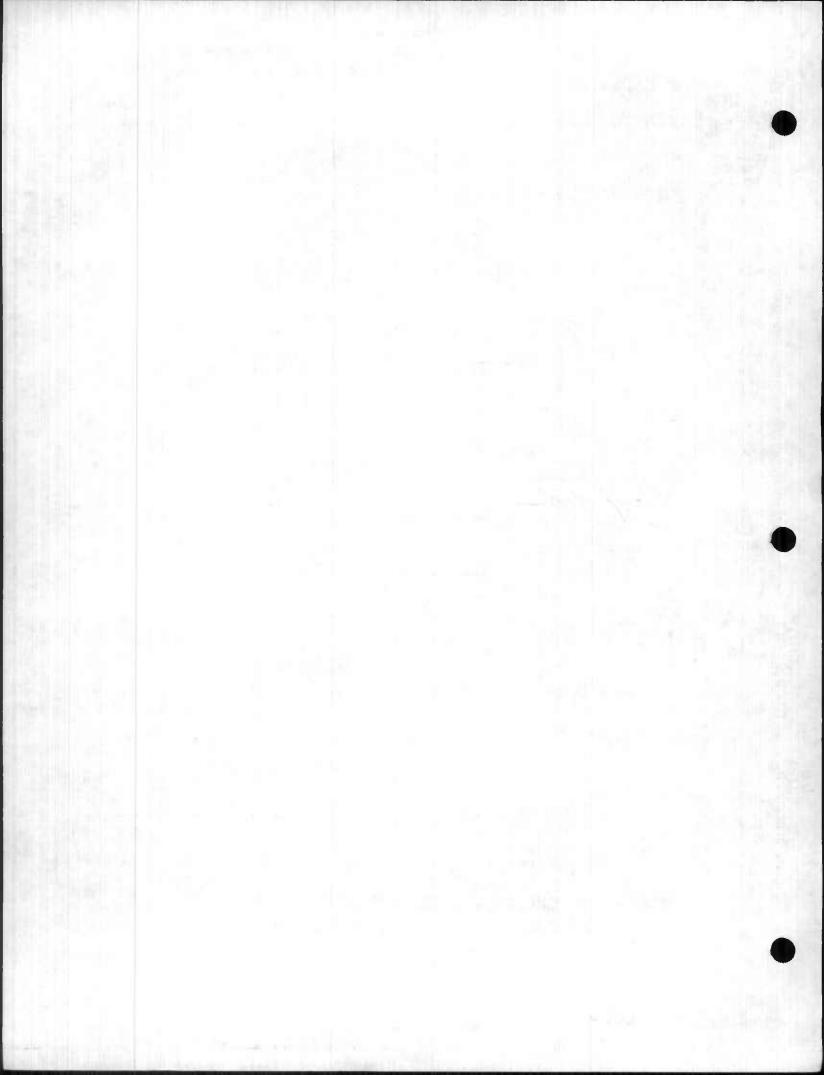
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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and and Tr 27			Sharon/	Wife	1				Road	l, Be		thesda, Maryland 20817			
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ti Pages 1	i		5 Other (Spec		Mon	tgomery					2000 Bethesda, Maryla				
Ball Ball	buce	21. Signature of Funeral Service Licensee  Robert A. Pumphrey Funeral Home/Bether 7557 Wisconsin Avenue Characteristics and Address of Fecility Robert A. Pumphrey Funeral Home/Bether 7557 Wisconsin Avenue Characteristics and Address of Fecility Robert A. Pumphrey Funeral Home/Bether Robert										Bethe Cha	sda-Chevy se, Inc.		
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10 P m lox 68760 h certificate be ending physicier	Ca	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of):													
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00 7 2 8 .	lon:	27. Manner of Death 1 Natural 5 Pending (Month, Dey Year) 28b. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28c. Injury et Work?									red				
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DIVISION To the Hospital or Attending Betting 24 hours after death.	edical Certification:	29e. Certifier  (Check only one)  29 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.													
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**DHMH 16 Rev 6/95** 



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2000 Sette Sept. 25, Barnett 3:30 AM. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery 6017 Madawaska Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 XF Days Yrs. 87 New York May 20, 1913 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Bethesda Montgomery 10f. Zip Code 10g. Citizen of Whet Country? 20816 6017 Madawaska Road USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Managing Editor Federal Reserve Board 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Franklin Barnett Jessie Cantrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6259 Executive Board J. Laurence Kent (Trustee) Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) National Memorial Park 09/27 Falls Church, VA 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service Licensee 5130 Wisc. Ave. NW., Washington, D.C. 20016 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Pneumonia I Month Due to (or as e consequence of): Aspiration of Oral Contents 6 Months Due to (or as e consequence of):

**Physician** /Medical Examiner

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signed by the attending physician

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Director: After this certific d in by the funeral director,

Examiner

Physician/Medical

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**Physician** 

/Medical

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Elizabeth

5. Social Security Number

579-16-9086 Usual Residence of Deceden

10a. State

Maryland

10a. Street and Number

Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

20a. Method of Disposition

Parkinson Disease

Due to (or as e consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death?

September 25, 2000

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Cerebral Vascular Disease

24b. Were autopsy findings evailable prior to completion of ceuse of deeth? 24e. Wes an autopsy

1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No

25. Was cese referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred

5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one)

DC6104

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas C. Havell, MD. 4201 Cathedral Ave. NW., Washington, D.C. 20016-4901

State Registra

31. Date filed (Month, Day, Year) OCT 02 2000

29b. Signeture end title of certifier

32. Registrar's Signature

**DHMH 16 Rev 6/95** 

Box 68760. D.O.

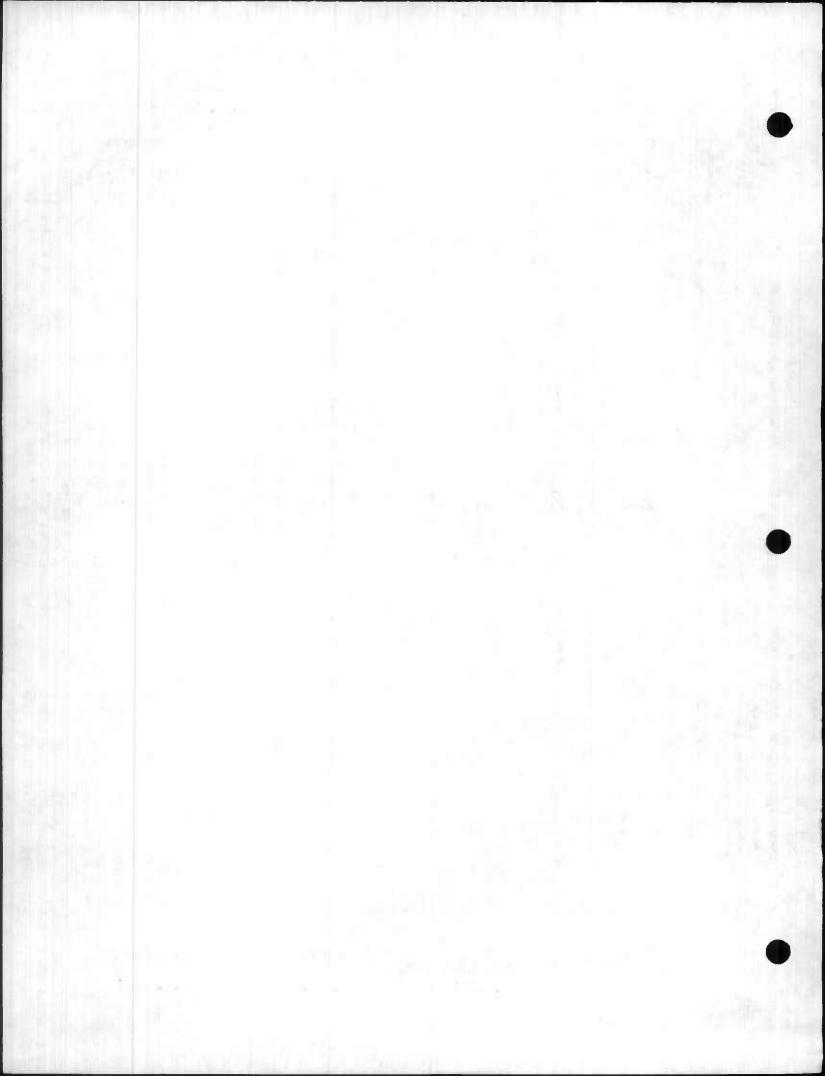
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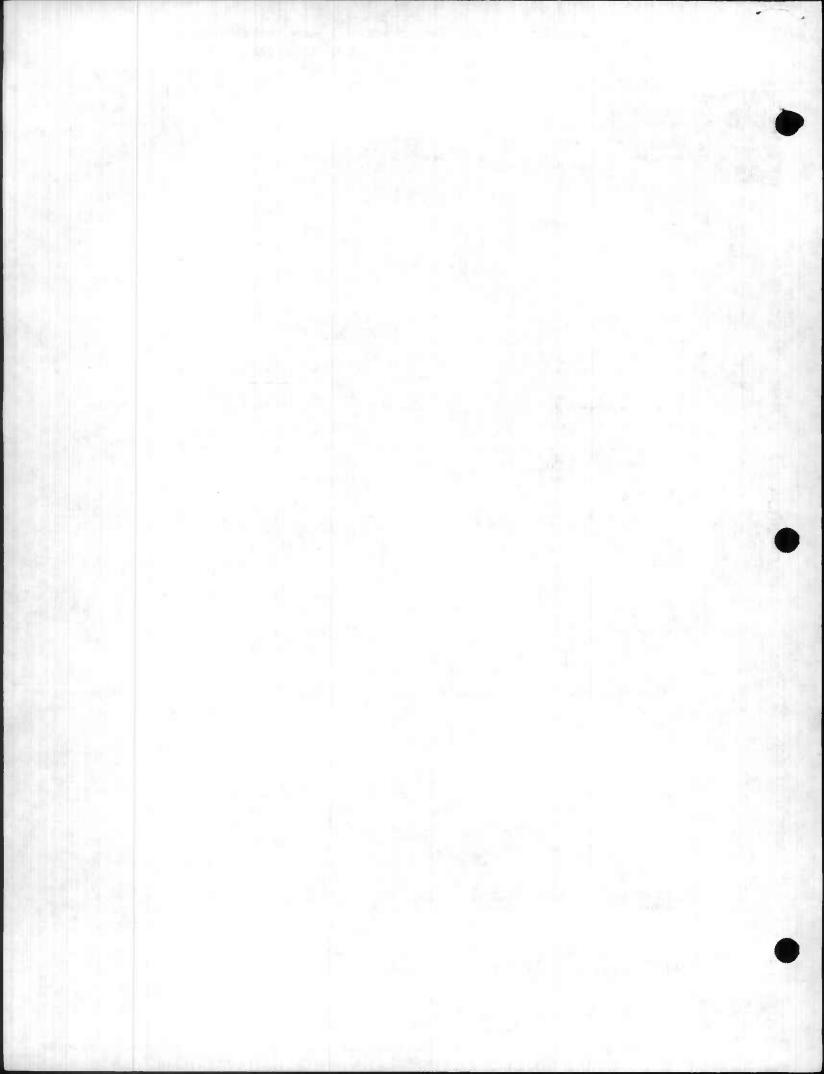
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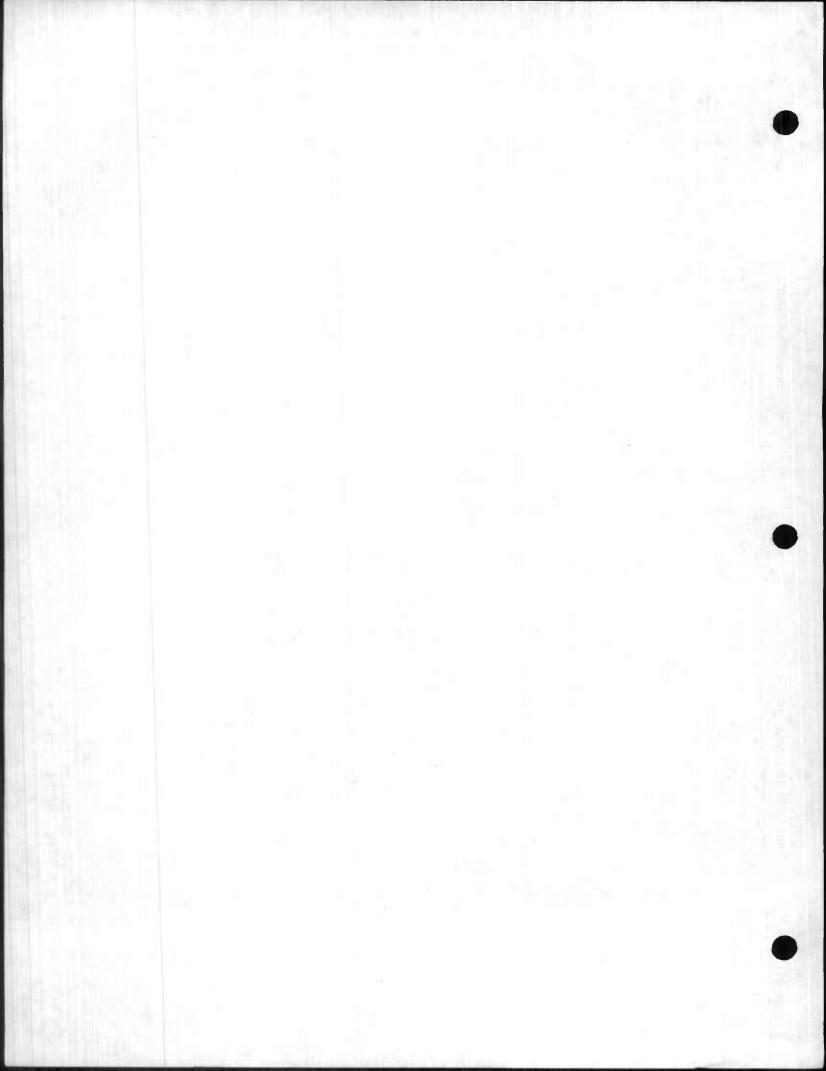
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0	Walter	Coxworth			LI TOTA			Isabel	McLenne	n				
		Name/Relationshi		3762				and Number or F				Zip Code)		
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State of Maryland / Department of Health and Mental Hygiene 10 22000

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HANS_SCHAEFFER 4a Facility Name (If not institution, give street and number)							Ab Cib. Town or	Month OCTOBER	4, 2000 Y	ear AM 1:45 ₱	
II Special								Location of Death	4c. County of		
5. Social Security F	Number 6. S	ex 7./		last birthda Yrs.			If Under 24 Hrs	8. Date of Birtl (Month, Day	h Year) 9	Birthplace (State or For Country)	reign
	10b. County		10c. Cit	y, Town or	Location					10d. Inside City Lin	imits
MD	MON	IGOMERY		BE	THESD	A				1 X Yas 2 □	] No
		WIN ROAD	#2317	,	10f. Zi		14		10g. Citizen of Who	at Country?	
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19e. Informent's N	leme/Relationship (7						end Number or R	ural Route Numbe	er, City or Town, St		814
20e. Method of Dis 1√2 Burial 2	position  Cremetion 3	Removel from Stat	0	emetery, cr	rematory or	other pla		OCT 6,			
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or ii. Other eight	meant continuone of	Similarity to doubt	50(110(100	oning in the	ondony my						
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axaminer?		Hospitel: 1 ☐ tnpe	itient 2	ER/Outpat	ient 3□ C	OA OI				(Specify)	
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29b. Signeture end	title of cadillar		3.12		25	c. Licen	se number		29d. Date signed	(Month, Day, Year)	
	11	de	70			2	625	9	117/	-/	
30. Neme and add	ress of person who	completed cause of	deeth (Iten	n 23e) (Tvn	e. Print)	10			101	100	
	9707 OLD 5. Social Security I 156-22-1 Usuel Residence of 10a. State MD 10e. Street and Nu 9707 OLD 11. Marital Status 1 Never Men 3 Widowed (Spe Elementery/Sec 17. Father's Name EMIL SCH 19e. Informent's N LILO SCH 20e. Method of Dis 1 Burial 21. Signature of F 23a. Part1. Enter shock, or her Immediate Causa disease or condition 21. Signature of F 23a. Part1. Enter shock, or her 1 madiated event resulting in death) 25. Wes case rete and the substituting in death) 26. Wes case rete and the substituting in death) 27. Menne of Deat 28. Wes case rete and the substituting in death) 29. Certifier (Check only one)	9707 OLD GEORGETO  5. Social Security Number 6. S.  156-22-1369  Usuel Residenca of Decedent  10a. State 10b. County  MD MON  10e. Street and Number  9707 OLD GEORGETO  11. Marital Status  1	9707 OLD GEORGETOWN ROAD  5. Social Security Number  6. Sex  156-22-1369  Usuel Residence of Decedent  10e. State  10b. County  MD  MONTGOMERY  110e. Street and Number  9707 OLD GEORGETOWN ROAD  11. Marital Status  1 Never Merried  3 Widowed 4 Divorced  15. Decedent's Education  (Specity only highest grade completed)  Elementery/Secondary (0-12)  College (1-40  5-17. Father's Name (First, Middle, Last)  EMIL SCHAEFFER  19e. Informent's Neme/Relationship (Type, Print)  LILO SCHAEFFER/WIFE  20e. Method of Disposition  1 Burial 2 Cremetion 3 Removel from State 1 Donation 5 Other (Specity)  21. Signature of Funeral Service Libration  Immediate Causa (Final disease or conditions resulting in death)  Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that imitated events resulting in death)  Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that imitated events resulting in death)  25. Wes case reterred to medical axaminer?  1 Yes 25 No  27. Manney of Death  1 Check only accided a Georgian Princip Cause (Disease or Injury that imitated events resulting in death)  28. Det of the (Morth, Information or Contributing to death Delation or Contributing to death Delations or Check only and Contributing Physicien: To the basis and menner (Check only one)  29 Medical Examiner: On the basis and menner or Check only one)	9707 OLD GEORGETOWN ROAD #2317 5. Social Security Number 6. Sex 7. Age (in yrs. 156-22-1369	970.7 OLD GEORGETOWN ROAD #231.7  5. Social Security Number	970 OLD GEORGETOWN ROAD #2317  5. Social Security Number   6. Sex	9707 OLD GEORGETOWN ROAD #2317 5. Social Security Number 6. Sex 15. Sex 15. Sex 15. Security Number 16. Sex 15. Sex 15	9707 OLD GEORGETOWN ROAD #2317  S. Social Security Number 6. Sex 15	9707 OLD GEORGETONN ROAD #2317 5. Social Security Number 6. Sex 9 M © F 8 8 Yrs. 10. Cety Town or Location 10s. State 10s. County 10s. Street and Number 10s. Street 1 and Number 10s. Street 2 No. Specify: 11s. Mariat Status 11s. Never Merried 20 Married 3 D Windows 4 D Divoced 11st December 1 Street 1 December 1 Street 1 December 2 No. Specify: 11st December 1 Street 1 December 2 No. Specify: 11st December 1 Street 2 No. Specify: 11st December 2 No. Specify:	9707 OLD GEORGETOWN ROAD \$2317  5. Social Social Social Foundation of the County of th	9707 OLD GEORGETONN ROAD \$2317  10. Given a state brindary   Student Deep   Student Plant   Student Deep   Student Plant Plant Plant   Student Deep   Student Plant Plant Plant Plant   Student Deep   Student Plant Plan



State of Maryland / Department of Health and Mental Hygiene

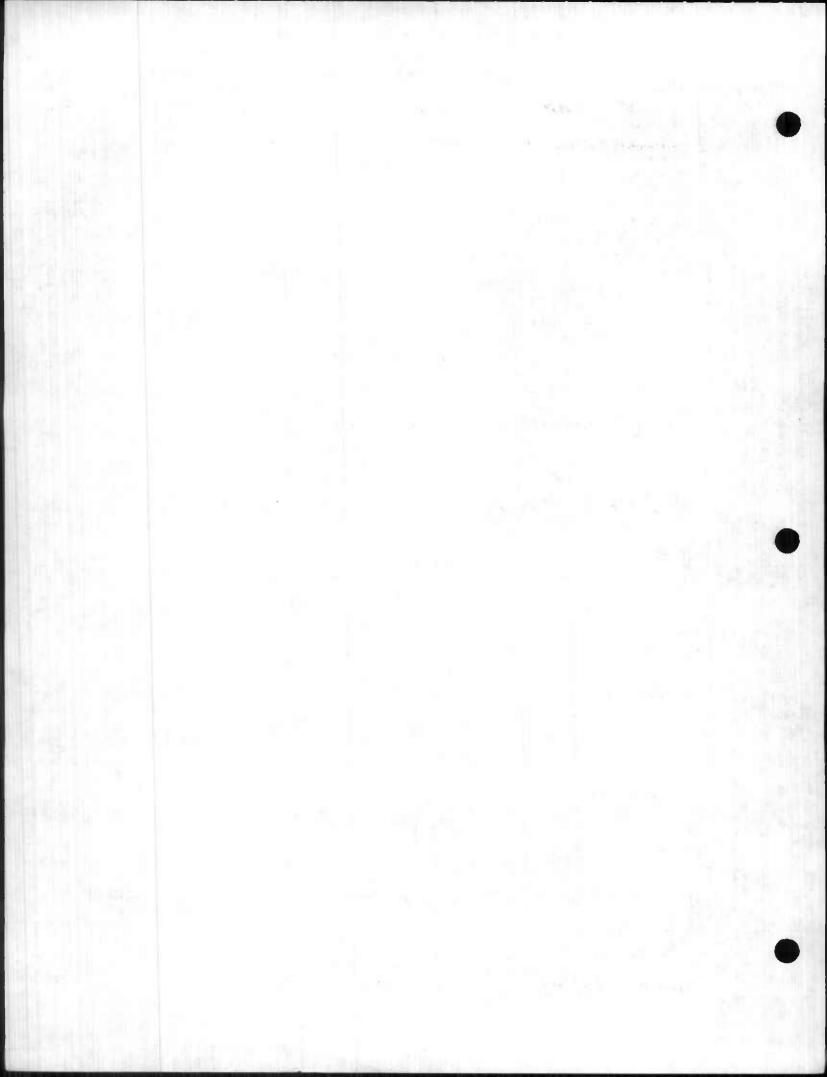
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Physician											
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/Medical	HARRY	VERNON		SCHNEI	DER				, 2000		9:30 A
Examiner	4a Facility Name (If not instit	tution, give street	and number)				4b. City, Town, or L	ocation of Death			
	SALISBURY CEN				Y 54 5 5		SALISBUR			OMICO	
Funeral	5. Sociel Security Number	6. Sex 1 ☑ M 2	OF	(In yrs. last bir	Mont	der 1 Year hs Days	If Under 24 Hrs. Hours Min.	8. Dete of Birt (Month, Da	th y, Year)	9. Birth	place (State or Fore intry)
Director	215-12-3704			86	Yrs.			July 3	), 1914	Mar	yland
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be notified	10e. Street and Number					Zip Code		10g. Citizen of What Country?			
	507 Railway					218	61		USA		
iner mast iner mast Funeral	11. Maritel Status	12. W	es Decedent E	ver in U,S.	13. Was De		fispenic Origin? (Sp an, Mexican, Puerto	pecify Yes or No			ican Indian,
sher ma sher ma	1 Never Merried 20		med Forces? ☐Yes 2☐ No Yes, Give	Dames/	1000			o Rican, etc.)		ck, White,	
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fo E	Louis S	chneide	r				Cather	ine Sch	reiber		
	19e. Informant's Name/Relei	tionship (Type, Pi	rint)	19b	. Meiling Add	ess (Street	and Number or Ru	ral Route Numb	er, City or Town	State, Zi	ip Code)
22	Louise T. Sc	hneider/	/Wife		PO Box	492,	Sharptow	m, MD 2	1861		
Ille offi	20a. Method of Disposition			20b. Place of	Disposition (	Name of or other place	ce)	Date	20c. Location	City or T	own, Stete
10 0	1 Burial 2 Cremat 4 Donation 5 Othe		el from Stete		ury Cr			10/4/00	Salis	sbury	, MD
arorta Se inju	21. Signeture of Funeral Sen	vice Licensee			22 Name	and Addro	es of Encility				
IFE	1 2. H	0 1/2					Funeral Hill Rd.				
	23a. Pert1. Enter the disease shock, or heart failure.	e, or complication	ns that caused t	the death. Do	not enter the r	node oi dyir	ng, such es cardiac	or respiretory e	rrest,	2 210	Approximete
sician	shock, or heart failure.	List only one cau	use of each line	9.							Onset and Deat
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miner	disease or condition resulting in death)	aC	May 193	ene	2-7 0	We-	er a			1	7100
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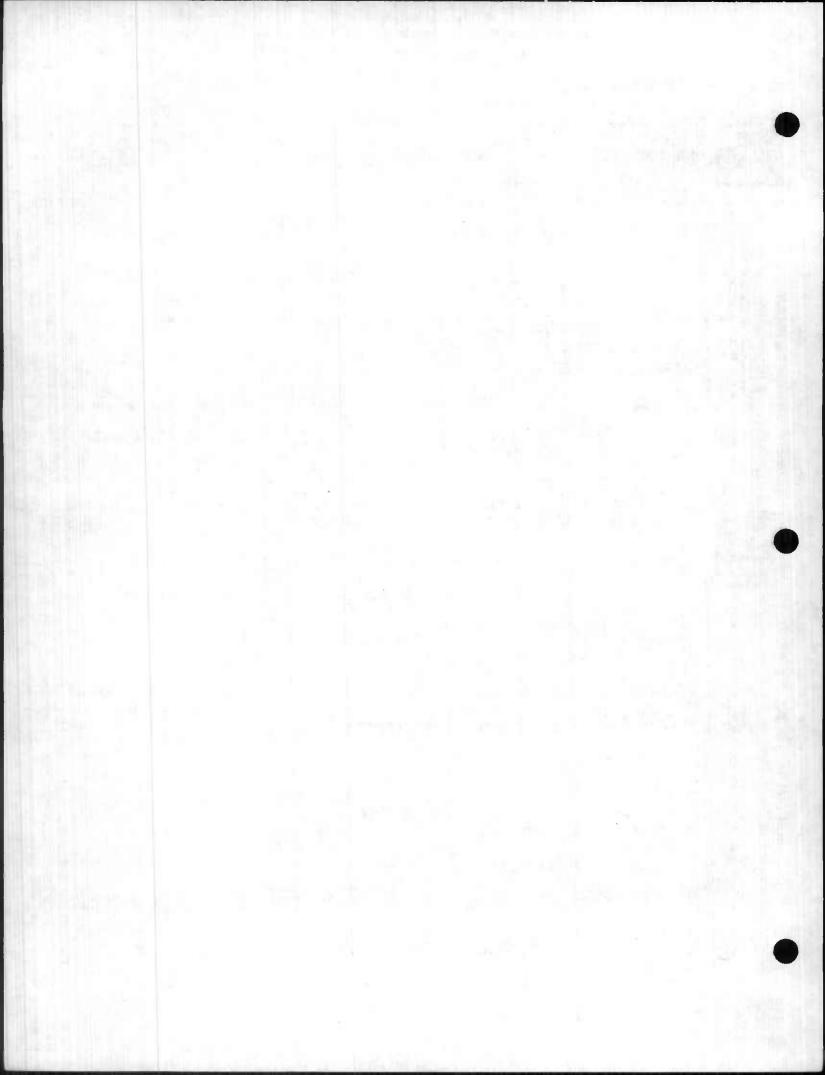
DHMH 16 Rev 6/95

Sparke



Minh Vinh Tran  4 Facility Name (If not institution, give street end number)  Mariner Health Care— Silver Spring  5. Sociel Security Number  8. Sax  1 Nonth Obey Year October 2, 2000 5:15 a  4b. City, Town, or Location of Death  4c. County of Death  Montgomery  5. Sociel Security Number  216—98—7315  Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  10c. City, Town or Location  10d. fiside City L	ical iner 4	Minh Vinh Tran  la Facility Name (If not institution, give  Mariner Health Car  i. Sociel Security Number  8. Sa	street end number)				Month	Dey						
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Ten   December   Students   Stu		**	If Yes, Give		1□ Yes 21 No	Specify:		Specify.	Asian					
Than Tran  The Informat's Name (First, Micdel, Last)  Than Tran  The Informatic Name (First, Micdel, Last)  Than Tran  The Informatic Name (First, Micdel, Last)  Than N. Tran / Daughter  200. Method of Disposition  (Color Plant of Disposition  (Col				16a Dac	edent's Henal Occur	nation		16h Kind of Bu						
18. Mother's Name (First, Micdle, Last)   18. Mother's Name (First, Micdle, Masclan Surname)   196. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   10. Windson Way, Camp Hill, PA 1701   196. Date of Department of Plant Route Number, City or Town, State, Zip Code)   10. Windson Way, Camp Hill, PA 1701   196. Date of Department of Plant Route Number, City or Town, State, Zip Code)   10. Windson Way, Camp Hill, PA 1701   196. Date of Department of Plant Route Number, City or Town, State of Department of Plant Route Number, City or Town, State of Department of Plant Route Number, City or Town, State of Department of Plant Route, City or Town, State of Department of D	olete	(Specify only highest grad	le completed)	(Giv	a kind of work done DO NOT use retire	during most o	f working	TOD. KING OF BU	siresarrioustry					
18. Mother's Name (First, Micdle, Last)   18. Mother's Name (First, Micdle, Mackins Surname)   196. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   10. Windson Way, Camp Hill, PA 1701   196. Date of Deposition of Deposition of Early (Part of Number of Rural Route Number, City or Town, State, Zip Code)   10. Windson Way, Camp Hill, PA 1701   196. Date of Deposition Reposition of Early (Part of Number or Rural Route Number, City or Town, State, Zip Code)   10. Windson Way, Camp Hill, PA 1701   196. Date of Deposition Reposition Reposition of Supposition of Supposition Reposition Repositio	mo		College (1-4or 5+)	Busi	nessman			Retail	Sales					
Than Tran  Than Tran  Than Inguinformatic Name/Relationship (Type, Print)  Tran N. Tran/ Daughter  20. Method of Disposition  (See Brail & Comment Service Licensee)  10. Windson Way, Camp Hill, PA 17011  20. Location - Cay or Town, State, Ze Code)  Cedar Hill Cemetery  21. Signalymore Fureral Service Licensee  22. Name and Address of Facility  Prantic J. Collins Funeral Home, Inc.  50. University Blvd., W, Silver Spring, MD 2  23a. Part, Enter the disease, or complections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory area.  Immediate Cause (Final resulting in death)  23. Sequentially list conditions  Cause (Disease or Thurly Doub to (or as a consequence of):  Due to (or as a consequence of):  Cause (Disease or Thurly Presbly)   Life Conditions of the Cause of the Cause of Cause of Character of Cause (Disease or Thurly Presbly)   Life Conditions of Cause (Disease or Thurly Presbly)   Life Cause of		17. Father's Neme (First, Middle, Last)				18. Mother's	Name (First, Middla	Maiden Sumam	e)					
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20b. Nemod of Disposition   Date   Documents   Date   Documents   Date   Date   Documents   Date   Date   Documents   Date   Documents   Date   Date   Documents	1	19a. Informant's Name/Relationship (7)	rpe, Print)	19b. Ma	iling Address (Stree	t and Number	or Rural Route Numb	er, City or Town,	State, Zip Code)					
## Clarametrics of Characterics of Characteric		Tran N. Tran/ Daug		10 W	indson Wa	y, Camp								
21. Signature of Foundations and Control of	2			Place of Disp cemetery, cr	position (Neme of remetory or other pla	есе)	Date	20c. Location -	City or Town, State					
Francis J. Collins Funeral Home, Inc.   500 University Blvd., W. Silver Spring, MD 2   23a. Part, Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   Approximate shock, or heart failure. List only directure on each fine.   Due to for as a consequence of:   Due to fo				edar H	ill Cemet	ery	10/5/00	Suitlar	nd, MD					
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29a. Certifier (Check only one)  29b. Signefure and title of certifier  29b. Signefure and title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)  29d. Date signed (Month, Dey, Year)		1 ☑Natural 5 ☐ Pending	28a. Data of Injury (Month, Dey Year)					how injury occurr	ed					
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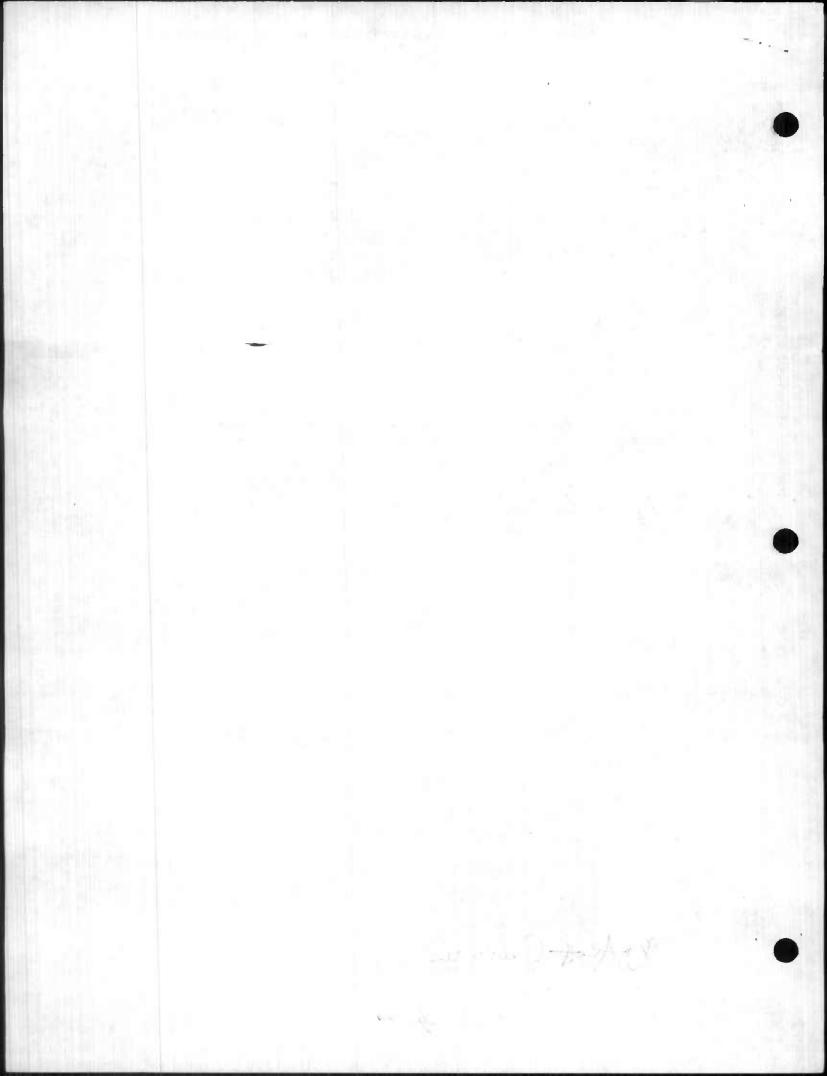
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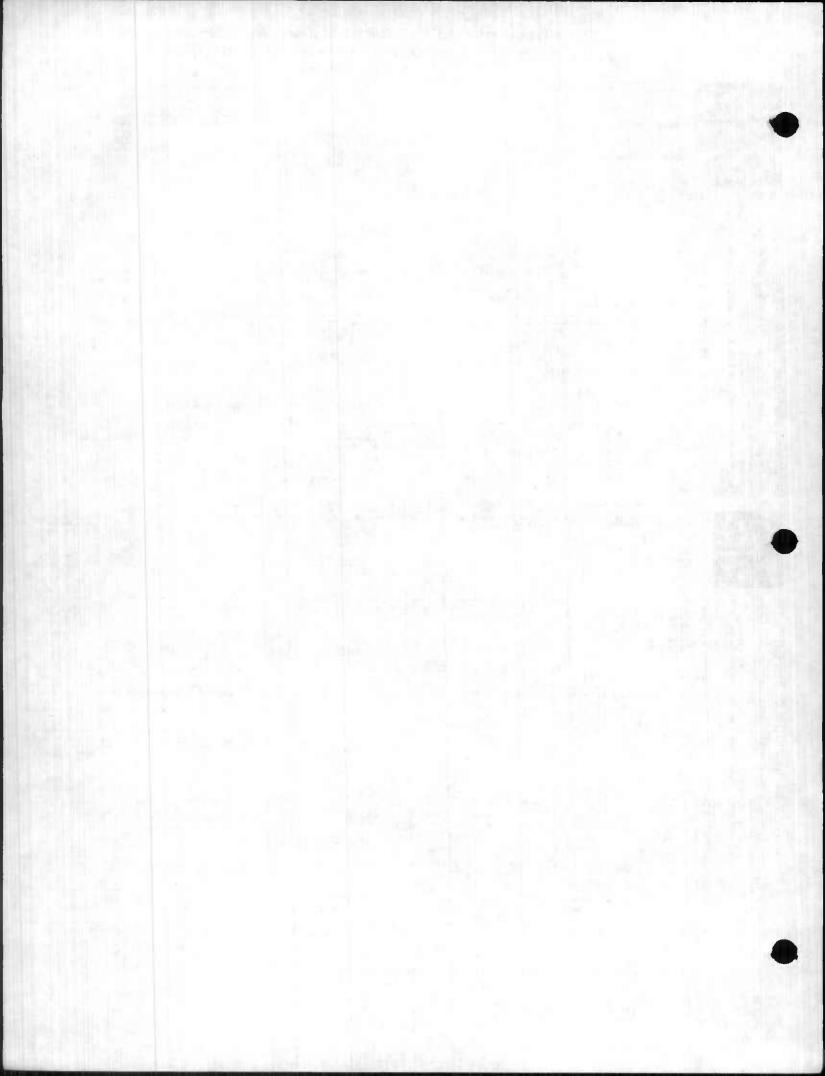
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cal		Elizab	eth I	aylor					Octobe			10:25	PM
4a Facility Neme (If not instit		and number)							cation of Death	4c. County	of Death		
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5. Sociel Security Number 579-12-9673 Usual Residence of Deceden	6. Sex 1 M 2		90	Yrs.	Months			Min.	8. Data of Birt (Month, De July 30	, Year) 1910	Pen	pieca (Stata or intry) nnsylva:	nia
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Maryland Mon  10a. Street and Number					10f. Z	ip Code	1-1-	- 11	10g. Citizan of W			intry?	
11. Marital Status  1 Never Married 2	08 Bayar	d Blvd			2	0816				United	d Sta	ates	
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John A. Mi			1	40)					. Spess		0		
19a. Informant's Neme/Relat										er, City or Town,			
Robert L. Tay  20e. Method of Disposition	IOI, JI.	/ 50H						Beth	Dete Dete	Maryland 20c. Location			
1 N Burlal 2 Cramati 4 Donetion 5 Othe	r (Specify)	el from State		ca of Disponetery, crem	L1 Ce	emet		 		Waynesb Pennsyl	oro,		
Immediate Ceuse (Final disease or condition resulting in death)  Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last  Pert II. Other significant con- Emphysema	aL. b c d		Due to (or a	as a conseques a conseques a conseques	uenca of	):						Months	
Pert II. Other significant con-	ditions contributir	ng to death bu	ut not result	ing in the ur	nderlying	cause gi	ven in Pert f.		**	tobacco use co			
Emphysema									14	Yss 2 No	3 Pro	obably 4 1	Unknow
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1 XNatural 5 Pe 2 Accident	nding estigation	i. Dete of fnjur (Month, Dey	Year) 2	8b. Time of Injury	М		ryat ork? ]Yes 2□N	No		how injury occur			
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29b. Signature and title of cer	tifiar				29c. License number			29d. Date signe	d (Month	, Day, Year)			
1 X Xe	of (	de	M	D42051					October 5, 2000				
30. Neme and address of per D. Scott Cohe 31. Data filed (Month, Dey, You	en, M.D.		Wisco	nsin		ue #	1125,	Che	vy Chas	e, Mary	1and	20815-	-46



State of Maryland / Department of Health and Mental Hygiene

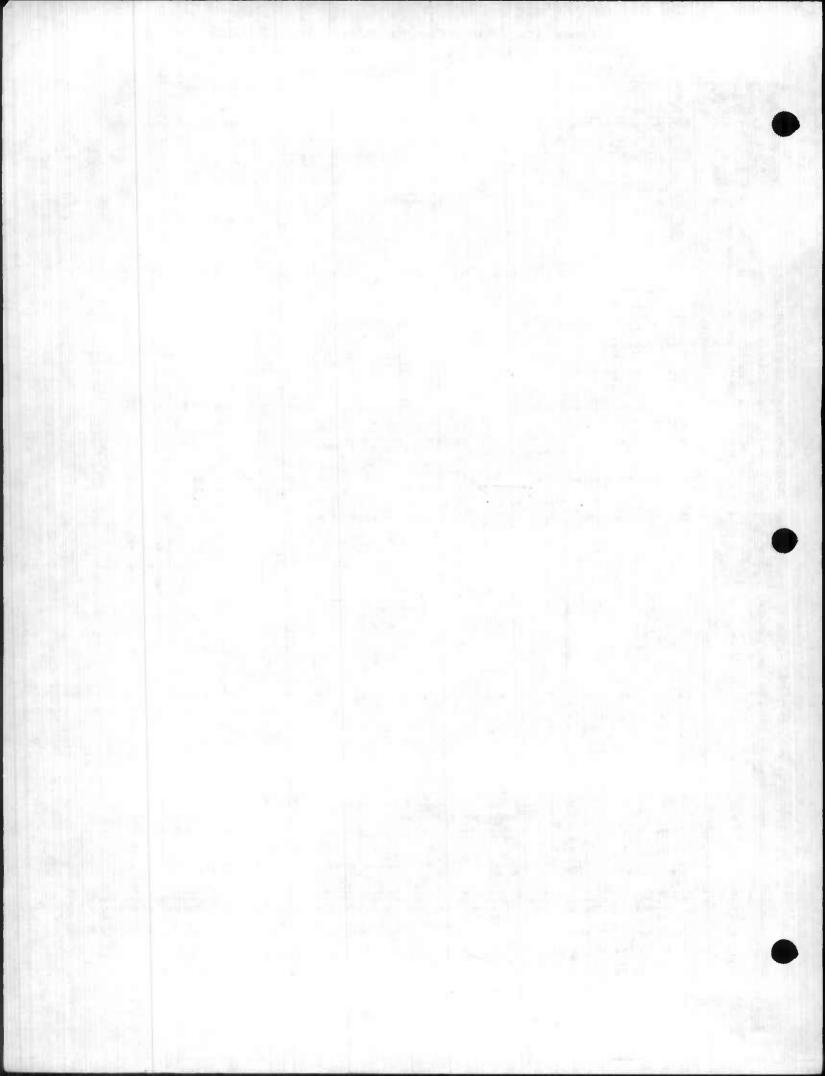
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	1. Decedent's Name (First, Middle, La	st)					1	ate of Death		Vana	3. Time of Death
hysician	Bernard	J.	Venverl	oh. 111				nonth ptembe	Day	Yaar	1:55AM
Medical kaminer	4a Facility Name (If not institution, giv			0.0, 2.2.2		b. City, Tow	vn, or Locatio		4c. County		I J. J.JAM
annie	Casey House					Panh	ville		Mont	aama	
	5. Social Security Number 6. S	ex 7. Aga	(In yrs. last birth	day) If Und	der 1 Yaar	If Under 2		ate of Birth Nonth, Dey, Y		9. Birtho	leca (Stete or Fore
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_	Usual Residence of Decedent						1400	ember	1.1700		
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ö	Maryland Montgo	m 0 to 11	Germant	0.4110							1  Yas 2 □ 1
Directo	10e. Streel and Number	nerg	Germana		Zip Code			100	. Citizen of W	Vhat Cour	ntry?
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5	11. Marital Stalus	Armed Forces?	Armed Forces?			in, Mexican,	Puarto Ricar	n, etc.)		k, White,	
by F	1 Nevar Marriad 2 Married 3 Widowed 4 Divorced	1 Yes 2 No	9	1 🗆 Yas	2 💢 No	Specify:			Specify		
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Completed	15. Decedent's Ed (Specify only highest gra		16a. L	Decedent's U: Give kind of the DO NOT	work done	ation during most o	of working	16	b. Kind of Bu	SIN9SS/IN	dustry
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		7	LLU.	CC ENV	Xionm		Engin	eer			
eg B	17. Father's Name (First, Middle, Last)					18. Mother	rs Neme (Fin	st, Middle, Ma	iden Sumam	θ)	
2	Bernard J. Venver	loh, Jr.				Joan	Hoffn	eister ute Number, (			
	19a. Informant's Name/Relationship (	Type, Print)	19b. I	Mailing Addre	ess (Street	and Number	r or Aurel Ro	ute Number, (	City or Town,	State, Zip	Code)
	Denise Frise	Sister	117	08 Old	le Enc	rlish	Drive.	Resto	n. Vir	aini	a 20190 own, State
	20a. Method of Disposition		20b. Place of I	Disposition (f	Veme of	ce)	De	ate 20	c. Location -	City or To	own, State
	1 Burial 2 Cremation 3 C		Columb	ia Gar	idens	Cemet	ery 10	/3/200	O Arli	ngto	n, VA
	2 Signature of Poceral Service Licer	*	1								
8	A MAIL	000	100	Rober	t J. i	Murphy	Fune	ial Hon	re, Inc.		
	· College	acceptante	15-21	4510	vilso	n Blud	. Arl.	Va. 222	03		
	23a. Part1. Enter the disease, or com shock, or heart failure. List only-		Approximete Interval Between Onset and Death								
	Charles and the second									-	Oriset and Death
	Immediate Cause (Final disease or condition	. Meta	astatic	Carci	noma					1	6 month
100	resulting in death)		ue to (or as e co								
Examine		Cold	on Cance	r					18 Month		
E	Sequentially list conditions,	b									
	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury										
edical	that initiated events	C	ue to (or as a co	nsequenca o	of):						
	resulting in death) Last										
M		d									
Physician/	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlyin	a cause aiv	ren in Part I.		23b. Did tobacco use contribute to the cause of			
ys	Tarrit digitilicant conditions	onthibuting to doubt but	mot rooditing in	and directly in	g outloo g	0.7 #7.1 4.11.1					bably 4 Unk
									2200	00	
d by								24a. Was an	autopsy	24b. W	ere autopsy findir
Completed			the still					performe	ed?	CC	vailable prior to emplation of cause
dE.									~		death?
S								1 🗆 Yes	2 No	1 [	Yes 2 No
Be	25. Was case referred to medical examiner?				100		of Deeth (Ch	eck only one			
2	1 □ Yes 2 X No	Hospital: 1 Inpatian		patient 3	DOA Oth	4LI NUF	rsing Home	5 Residen	ca 6 XOth	er (Speci	m) Hospic
:u	27. Manner of Death  1 Natural 5 Pending	28a. Dete of Injury (Month, Day	Year) 28b. Ti	me of ury	28c. Inju	y at k?	28d.	Describe hov	injury occur	red	
atio	2 ☐ Accident Investigation	n		М	10	Yes 2 N	No				
il for	3 Suicida 6 Could not b	e 28e. Placa of Injur	y - At home, fam	n, street, fac	tory, offica			ocation (Stre		er or Run	al Route Number,
e	27. Manner of Death  28a. Dete of Injury  (Month, Dey Year)  28b. Time of Injury at In								J. 1. 1. 7		
edical (	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best of niner: On the basis of e and manner state	examination and	death occurr or investiget	ed at the til	ne, dete end pinion, deatl	d plece, and o	lue to the cau the time, dat	se(s) and ma e and place,	inner as s and due t	stated. o the cause(s)
ě		and mariner state	eu.		29c. Licans	e number		29	d. Date signe	d /Month	Day Year)
5	29b. Signature and title of cartifier	1.1			D09						9,2000
/	T. T.	Libre	MI						CT T CMK	/ 61 2	, 2000
	30. Name and address of parson who	complated cause of de	ath (Item 23a) (T	ype, Print)							
	Eugene P. Libr	e. MD 102	400 Conn	oction	it Au	onno	Konsin	atan	Md 20	1805	
State	31. Date filed (Month, Dey, Year)	32. Registrar			A	et blike p	N. C. COAL	yaut,	21311 4 61	0.7.	
istrar	OCT 0 2 2	200	me /	1 1.	200						



State of Maryland / Department of Health and Mental Hygiene

				Cer	titicate	or	Death			Reg. No.		0 2 0 0 0
Physician	1. Decedent's Nema (First, Middle,								2. Data of Do Month	Dev	Yeer	3. Time of Death
/Medical		ainqueur					# 00 T		_		2000	12:41 AM
Examiner	4a Fscility Name (If not institution,		iber)						ocation of Deal			
	Holy Cross Hos		7 Age /le leas	e desimble de la l	If Undar 1	Vear			Spring		tgome	-
Funeral	579-90-8701	1⊠M 2□F	7. Aga (In yrs. lasi 69	Yrs.		Deys		Min.	(Month, Di	3, 1931	Hai	olaca (Steta or Foreig ntry) T-1
Director	Usual Residence of Decedent		0,7			-			our) 2	3, 1731	1141	
ahow ahow	10a. State 10b. County		10c. City, T	own or Loc	cation							10d. Inside City Limits
death with the Meryland THE 23s or 28s-f show Frame by notified at	Maryland Montgo	mery	S	ilver	Sprin	ng						1 ☐ Yes 2 ☑ No
or 28a-f a	10e. Street and Number			- 90	10f. Zip Code					10g. Citizen of	Whet Cou	ntry?
23a c	1319 Gresham Roa	d		20904						Hait	i	
r Rems 234	11. Marital Status	12. Was Deced	dent Evar in U,S.	13. V	Vas Decede	nt of I	Hispanic Orig	gin? (Spo	ecify Yes or No Rican, etc.)	)- 14. Rac	a - Ameri	can Indian,
	1 Never Married 2 Marrie		21 No		☐ Yas 2					Specifi		lack
leted by	3 Widowed 4 Divorced	Year or Da	tes:									
r, the Medical Completed	15. Decedent's (Specify only highest	Education grade complated)		6e. Deced (Giva	ent's Usual kind of work	done	pation during most ed)	of work	ing	16b. Kind of B	usiness/In	dustry
omp	Elementery/Secondary (0-12) None	Cottege (1-	4or 5+)				engine			Voice	of Am	orion
ပိ	17. Father's Name (First, Middle, La	et)		Hain	Lenand				e (First Middle	, Maiden Suman		ierica
o Be	Tigon Vainqueur									btainab		
F	19a. Informant's Name/Reletionship	(Tyme Print)		10h Maitin	a Addrose /	Stree				per, City or Town,		Code)
200	Jacques Vainqueu									ing, Ma		
off.	20a. Method of Disposition				sition (Neme			1	Date	20c. Location		
Og	1 ☑ Buriat 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (See		Hale					, 10	/07/00	Silver	Spri	na MD
any injury or other traumatic avent, once.	21. Signature of Funeral Sarvice Li		Jace							ldi Fun		
Duce.	Jan Dto	hutil	7	1	1800 N	Vew	Hamps	shir	e Avenu	ie		
	The Part V Eyler tha diseasa, or co	omplications that ca	used the death.				ring,			20904	1	Approximete
ician	Part Fixer tha diseasa, or complications that caused tha daath. Do not enter tha mode of dying, such as cardiac or respiretory arrest, heart failure. List only one cause on each line.											Intervel Between Onset and Death
dical	Immediate Cause (Final	D									i	Davia
iner	disease or condition resulting in deeth)	a. Phet	monia Due to (or e		upage of):						1	Days
je	DATE TO ANY	Cere	ebrovasci			ent					1	Days
ami	Sequentially list conditions,	b	Due to (or a:									
es me bunat-transit ledicai Examir	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury										1	
/Medical Examiner	that initiated events resulting in death) Last	Ü	Dua to (or as	a consequ	uence of):							
We es		4										
			13 2011								t t	
etached for u Physician	Pert ti. Other significant conditions	contributing to dea	ath but not resulting	ng In the un	derlying cau	ıse gi	iven in Pert I.		23b. Did	tobacco uss co		o the causs of death?
deta Ph	Hypertension								1	Yes 2 No	3 Pro	bably 4 🖸 Unknow
2 2								117	24e Wa	s an autopsy	24b. W	ere autopsy findings
2 should							1 15		perf	ormad?	CC	vailable prior to emplation of causa
page 2 should												death?
										Yes 2 No	1	☐ Yes 2☑ No
Be	25. Wes case referred to medical examiner?	Hospital:			-5	Ot	her:		h (Check only		- 15	
72	1 Yes 2X No 27. Menner of Death	28e. Dete of	1	VOutpatient  Bb. Time of			4 LI NU	rsing Ho		how injury occur		fy)
the funeral cation:	1 Neturel 5 Pending 2 Accident Investige	(Month	n, Dey Year)	Injury	м	Wo	ork? ]Yes 2∐l	No				
y the	3 Suicide 6 Could no	et, factory,	office	1				ber or Rur	al Route Number,			
Certification:	4 Homicide	buildin	g, etc. (Specify)						City or To	iwn, Stete)		
		Physician: To the b										
completely filled in by Medical Certifi	(Check only 2 Medical Ex	aminer: On the bas and menne		and/or inv	estigetion, in	n my	opinion, deel	th occur	red at the time	, date and place,	and due t	to the cause(s)
completely filled in by the fune Medical Certification	29b. Signatura and title of certifiar				29c.	Licen	se number			29d. Date signe	d (Month,	Dey, Year)
2	hepyps	M	2			D3	2332			Septembe	er 28	, 2000
	30. Nama and address of person wi	no completed cause	of deeth (Item 23	3a) (Type, f	Print)		3 1940	Fine I		1 1 1		
	S.K. Gupta, M.D.	9801 G	eorgia A	venue	, #220	0,	Silve	r Sp	ring, 1	Maryland	209	902
State	31. Date fited (Month, Dey, Year)		lgistrer's Signature	14	600	0 1	4					
Registrar	OCT 0 4	2000	There	10.	1900	490						

DHMH 16 Rev 6/95



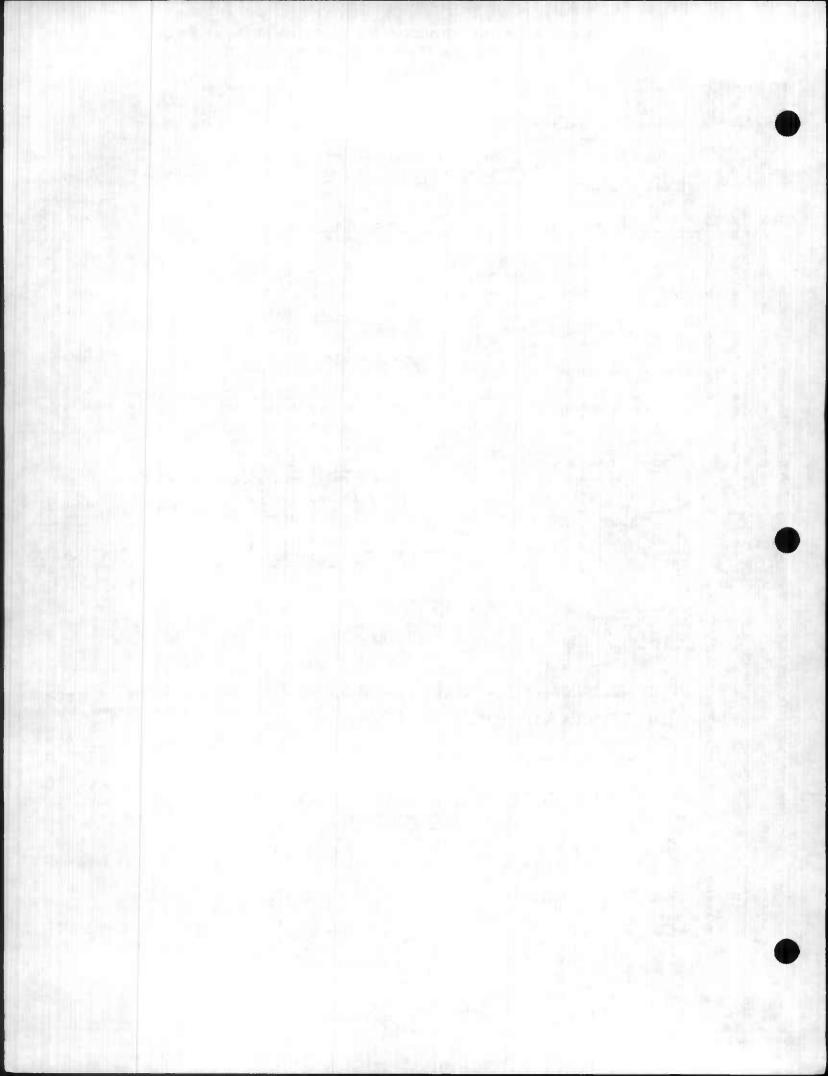
00-5525-045 cm Maria Vargas

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

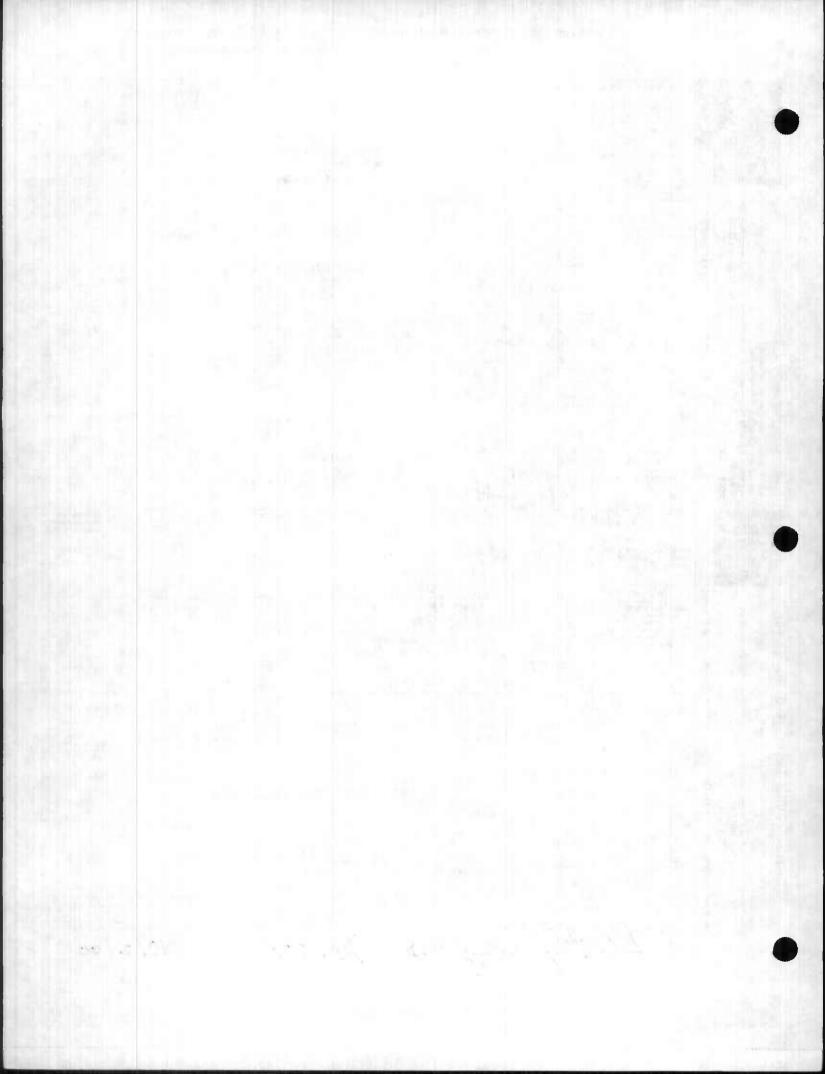
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3			Certificate of	Death	Re	g. No.	0 6	000
	1. Decedent's Name (First, Middle, La	st)			2. Dete of Death	1	3. Time o	f Death
hysician	MARIA	VARGAS			Septembe		2000 12:26	5 P.M
/Medical Examiner	4a Facility Name (If not institution, giv			4b. City, Town, or L	-	4c. County o		
Kailillei	Peninsula Regiona	al Medical Cente	er	Salisb	irv	Wico	omico	
ral	5. Social Security Number 6. S		1 1111 1 111			1		or Foreign
r		□M 2/2 F 2 5	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) -74	9. Birthplace (State Country)	X ICO
	10a. State 10b. County	10c. City. 7	Town or Location				10d. Inside C	Ity Limits
5								2 No
Ç	MD Wicon	MICO -	DALISBURY					
Funeral Director	10e. Street and Number		10f. Zip Code		10	og. Citizen of W	hat Country?	
20	605 (704)	DSBOROUGH >	)T. 2	1801		11/	EXICO	
ine	11. Marital Status	12. Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent of If Yes, specify Cul	Hispanic Orlgin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		<ul> <li>Americen Indian,</li> <li>White, etc.</li> </ul>	
-	1 Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ No If Yes, Give	1 Yes 2 No				4.4	
I	3 ☐ Widowed 4 ☐ Divorced	Year or Detes:	124 100 213110	Specify: ME	KICAN	Specify:	MEXIC	AN
	15. Decedent's Ed		16a. Decedent's Usual Occu	upation	1	16b. Kind of Bus	iness/Industry	
	(Specify only highest gra	College (1-4or 5+)	(Give kind of work done life. DO NOT use retin	ed)	ang	Λ		
	12	College (1-401 3+)	HOUSEK	EEPER		COMF	ORT IN	N
	17. Father's Name (First, Middle, Last,	) —————————————————————————————————————	7,00,- 61		e (First, Middle, M	laiden Sumame	)	
	JESUS	VARBAS		SABINA	Gan	10 V/10	GAS	
	19a. Informent's Name/Relationship (		19b. Meiling Address (Stree		THE BOURD Number	City or Town	0.70	
	/				. 1 - 1		^	
		REAS BROTHER -	2494-DREW	VALLEY TO		LANTA.	GEORGIA	
	20a. Method of Disposition  12 Burial 2 □ Cremation 3 □	Removal from State	e of Disposition (Name of etery, cremetory or other pl	ace)	Date	OC. LOCATION - C	City or Town, State	
	4 ☐ Donation 5 ☐ Other (Specif	y) ELF	PANTEON DE JE	- IALPA 1	Helanon J	IUTEPE	C. MORELOS	- Me
	21 Signature of Funetal Service Licer	1809	22. Name and Add	ress of Facility	ENNIES	MITHE	PH	- 1100
	90 M	14	917W.Is	ABELLAS	- 6.		Μ	
_	200 Part Fatance	102	7	HBELLIN O	7. JALIS	BURY	MD. 218	
	23a. Pert1. Enter the disease, or com shock, or heart tailure. List only	one ceuse on each line.	Do not enter the mode of dy	ying, such es cardiec	A are	ist,	Approxima Interval Be Onset and	tween
		-1		0	0	11.	Onset and	Death
	Immediate Ceuse (Final disease or condition	110	tracer	eva	1	Hew	worne	Re
	resulting in death)	Due to (or e	s a consequence of):					0
	Sequentially list conditions.	Due to (or as	s a consequence of):					
	Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury							
	THAT WHITE DOUBLING INCH	C. Due to (or as	s e consequence of):					
	resulting in death) Last	20010 (0. 00						
		d						
ı								
	Part II. Other significant conditions of	ontributing to death but not resulting	ng in the underlying ceuse g	iven in Part I.			tribute to the cause	
	Lintrau	terine 1	presna	ncy	1 🗆 Ye	s 2º No	3 Probably 4 ☑	] Unknow
-	7		0	-				
					24a. Wes er perform		24b. Were autopsy available prior	to
						/	completion of of death	cause
1					10/0	s 2 No	10 es 20	] No
	25. Wes case referred to medical			OS Diseas - A D			-	1775
1	axaminer?	Hospital:		Wher:	th (Check only one			
	Yes 2 No	1 X Inpatient 2 LEA	Voulpatient 3L DOA	4 U Nursing H	ome 5 Reside			
	27. Manner of Death 1. ■ Naturat 5 □ Pending	(Month, Day Year)	Bb. Time of 28c. Injury W		28d. Describe ho	m injury occurre		
	2 Accident investigation		M 1[	☐ Yes 2 ☐ No				
	3 ☐ Suicide 6 ☐ Could not b		e, farm, street, factory, office	9	28f. Location (Str. City or Town	reet and Numbe , Stete)	er or Rurel Route Nu	mber,
	29a. Certifier 1□ Certifying Ph	ysician: To the best of my knowle	dge, death occurred at the	time, date end place,	and due to the ca	use(s) end mer	nner as stated.	
3000	(Check only 2 Medical Examone)	niner: On the basis of examination and menner stated.	and/or Investigation, In my	opinion, death occur	red at the time, da	ate and place, a	nd due to the cause	(S)
E	29b. Signature, and title of certifier	0.282	29c. Licer	nse number	29	9d. Date signed	(Month, Dey, Year)	
	b / P	+ 1	AN	O.C.M.E.	Se	eptember	30, 2000	)
Ì	414	raner, V	ートワ		30	1		
	30. Name any address of person who	completed ceuse of death (Item 23						
l	1 Llose	In Pestaner	111 Penn S	treet, Ba	ltimore,	Marylar	nd 21201	
	31. Date filed (Month, Day, Year)	32/Registrar's Signature	64 /					
ate rar	OCT 0 4 2000	1	D. Sparks	/				



State of Maryland / Department of Health and Mental Hygiene 32227

			C	Pertificat	e of	Death			Reg. No.		0400		
	1. Decedent's Nama (First, Middle, Last)  2. Date of Death  Month Day Yaar										3. Time of Death		
Physician	Bertha Cordelia	Wright						Septen	mber 30,	200	0 2:00 PM		
/Medical Examiner	4a Facility Name (If not institution, 8015 Maple Ave.			No.		b. City, Too Takon		ation of Daath rk	4c. County Mont		ry		
Funeral Director	5. Social Security Number 577-28-3549	5. Sex 1  M 2	ge (In yrs. last birtho 84 Yrs		1 Yaar Days	If Undar	24 Hrs. Min.	8. Data of Bird (Month, Da Feb 16	y. Year) 0, 1916	9. Birthi Cou	place (State or Fore ntry)		
9	Usual Residenca of Decedent												
a-f show unled at ottor	MD 10b. County MD Montge	omery	10c. City, Town of Takoma								10d. Inside City Lim 1 ☐ Yes 2 ☐		
her death with the Maryta lister 23s or 28e-f sho finer must be notified at Furneral Director	10a. Street and Number 7051 Carroll Av	e. #405		10f. Zip	Code				10g. Citizen of V United				
un after death v	11. Marital Status 1 Nevar Marriad 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1	Ever in U,S.	13. Was Dece If Yes, spe 1 \(\sum \) Yes		ispanic Origin, Mexican Specify:	gin? (Spec I, Puerto F	cify Yes or No Rican, etc.)	Specific Black	ck, White,	can Indian, etc.		
be lied within 72 ho tal Hygiens. d other then "naturn event, the Medical Se Be Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		5+)	16a. Decadent's Usuel Occupation (Give kind of work done during most of work life. DO NOT use retired)  Film Assembly Strippe					16b. Kind of B		odustry vernment		
ad other th event, the	17. Fathar's Nama (First, Middle, La Claude Davis	r's Name		Meiden Sumen	ne)								
1 455 C	19e. Informent's Name/Reletionship						er or Rural		er, City or Town,				
rages 1 and 2 and 2 and 1 and 1 and 2 and 1 and		☐Removal from State	20b. Place of D	isposition (Na crematory or c	ne of other place	ce)	0	Date 11	20c. Location	City or To	own, Stata		
Separtman mportant my injury sice	4 Donation 5 Other (Specify)  21. Signature of Funaral Service Licensee  22. Name and Address of Facility Rapp Funeral & Cremation Services												
	23a. Part 1. Enter the disease, or co shock, or heart failure. List or	omplications that causa nly one cause on each i	d tha death. Do not ine.			Avenu				MD	Approximate Interval Between Onset and Death		
hysician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Swallo	wing Dysf	unction	n					1	1 year		
niner		Dement	Due to (or as a con ia	nsequenca of):							years		
physician and as the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury	Parkin	Due to (or as a cor son's Dis						Yall		years		
E	that initiated evants resulting in death) Last	■ d	Dua to (or as a cor	sequanca of):						1			
d by the attenderace of the stander	Part II. Other significant conditions	contributing to death b	out not resulting in th	ne underlying	ause niv	en in Part I.		23b, Did	tobacco use co	ntribute t	to the cause of dea		
igned by the be detached by Physical by Ph	Hepatitis A							10	Yes 2 No	3 Pro	obably 4 Unkn		
been s should								24a. Was	an autopsy ermed?	av	Vere autopsy finding vailable prior to ompletion of cause I death?		
Dage Dage	25. Was case referred to medical					00 pl	-1 D1	10		1	□Yes 2 No		
nysician nis certific il director	examiner?	Hospitel: 1 ☐ Inpati	ant 2 ER/Outp	atient 3 D	Oth Oth			(Check only one 5 □ Besi	denca 6 Dott	ner (Speci	Group  (b) Home		
Attending Physician: or death. ector: After this certific by the funeral director, ification: To Be (	27. Manner of Death  1 D Slatural 5 Panding 2 Accident investiga	28a. Date of Inju (Month, Da	ry 28b. Tim	ne of	28c. Injur Wor		2		how injury occur		w nome		
to the neoptals or Amending Pro Within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 7	3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28e. Pleca of Injury - At home, farm, street, factory, offica City or Town, State)										al Route Number,		
within 24 hours after to the Funeral Dir. To the Funeral Dir. Completely filled in Medical Cert	29a. Certifier (Check only one)    Check only one)												
Within Comp	29b. Signature applittle Contilled	7 /	1	29	c. Licens	e number			29d. Date signe	Month,	, Day, Year)		
10	30. Nama and address of person wh	fully completed cause of	Math (Item 22a) (T.	me Print)	03	100	/		10,	/2/	00		
	Stuart J. Turk	ewitz M.D.	7500 Gree		ente	er Dr.	#43	0, Gre	enbelt,	MD 2	20770		
State Registrar	31. Date filed (Month, Day, Year)	0000	rar's Signature	lo	alls								



#### **Please Ty**

Type or Print In Black Indelible Ink. Assure	All Coples Are L	egible.	
State of Maryland / Department of Health and	Mental Hygiene	00 3	12888
Certificate of Death	Reg. No.		, 0 0 0
nst)	2. Date of Death	Vest	3. Tima of Deat
Worsham	Oct. 4	2000	3:50A.

**Physician** /Medical Examiner

4a Facility Name (If not institution, give street end number) Holy Cross Hospital 5. Social Security Number

C.

1. Decedent's Name (First, Middle, Last)

4b. City, Town, or Location of Death

4c. County of Death

**Funeral Director** 

25a-f a

mark be n

or itsems

al Hygiens. d other than "naturel", or event, the Medical Exam

Pages 1 and 2 should be the mont of Health and Mental H tant: If hem 27 is marked off ilury or other traumatic even

filed within 72 hours after

Baltimore, Maryland 21215-0020

Director

Funeral

ď

Completed

Be

Physician/Medical Examine

p

Be Completed

edicai Certification: To

579-76-0278 Usual Residence of Decedent 10a, State 10b. County

Darlene

1□M 2√2 F 41 Yrs.

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Months Deys Hours Sept.16,1959

Silver Spring Montgomery Birthplace (State or Foreign Country)

10c. City, Town or Location Prince George's

Beltsville

Supervisor

10d. Inside City Limits 1 ☐ Yes 2X No

Washington, D.C

10e. Street and Number

Maryland

11310 Cherry Hill Road

10f. Zip Code 20705 10g. Citizen of What Country? United States

11. Merital Stetus 1 Never Married 2 Married

12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:

 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

3 Widowed 4 Divorced

15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry U.S. Government

17. Father's Neme (First, Middle, Last)

Christopher Ray Payne Maxine

18. Mother's Name (First, Middle, Meiden Sumeme) Willie

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) same as #10

Kenneth T. Worsham (husband)

20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State

20e. Method of Disposition

1 Burlal 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)

Fort Lincoln Cemetery 10/7/2000 Brentwood, Maryland

21. Signature of Funeral Service License

Donald V. Borgwardt Funeral Home, P.A.

4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

**Physician** /Medical Examiner

The law requires that the death certificate be executed

signed bedet

9090

this

After

ours after death. eral Director: Afr filled in by the fu

within 24 hours a To the Funeral E completely filled

Box 68760.

P.O.

Division of Vital Records.

To the Hospital or Attending Physician:

Arterior Myocardial Infarction Due to (or as e consequence of):

2 days

Immediate Cause (Final disease or condition resulting in death)

Coronary Artery Disease Due to (or as a consequence of):

6 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown

Complete heart block

Non insulin dependent Diabetes Mellitis

24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy

Hypertension

26. Plece of Deeth (Check only one)

1 Yes 2 No 1 Yes

25. Was case reterred to medical examiner? 1 Yes 2 No 27. Menner of Death 1 Meturel

5 Pending investigation 6 Could not be

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28c. tnjury at Work? 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 Yes 2 No

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier

2 Accident

3 Suicide

4 T Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature end title of certifier

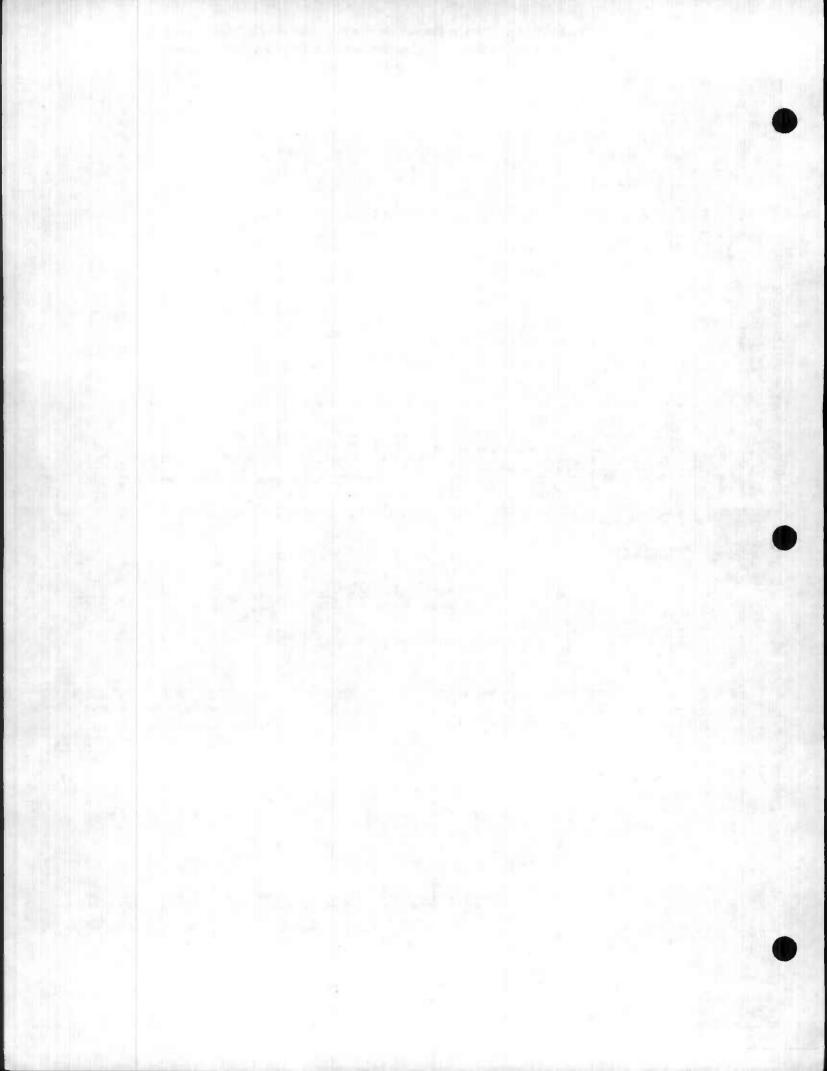
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October 4, 2000

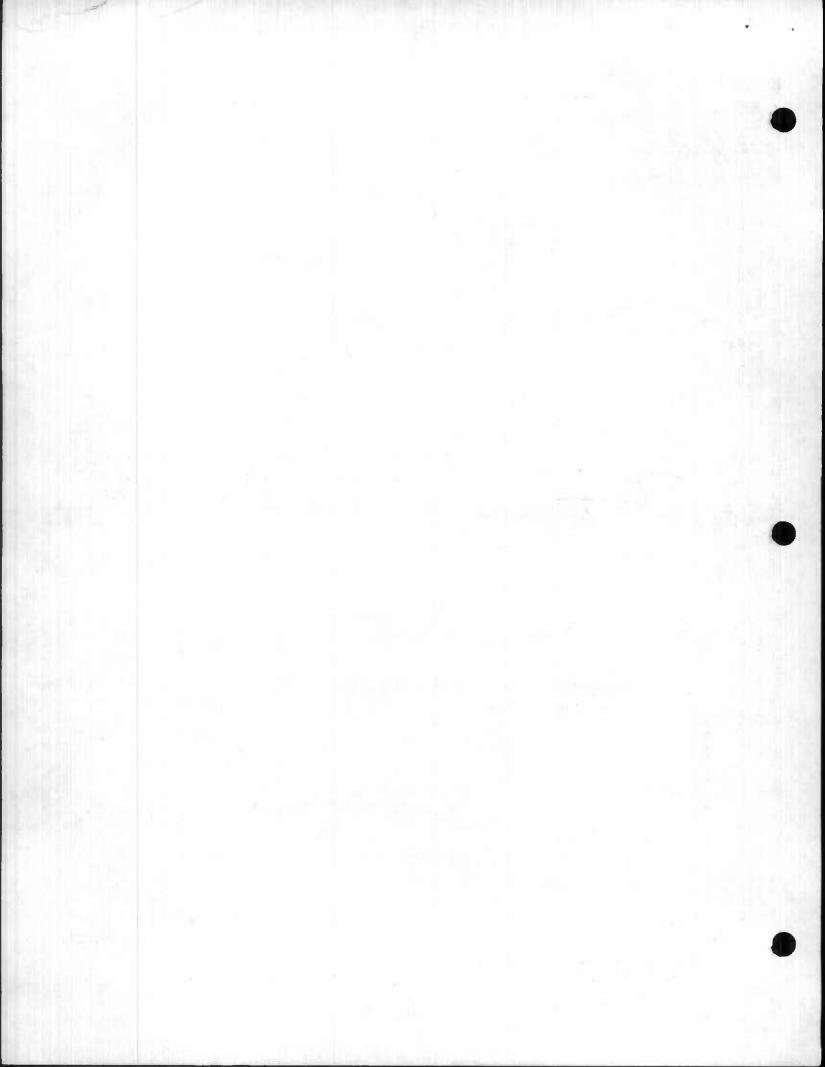
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

Brian Regan, M.D. Kaiser Permanente 1500 Forest Glen Ave. Silver Spring, Md. 20901

State Registrar 31. Date filed (Month, Dey, Year) OCT 65 32. Registrer's Signeture Seneva



		State of Mary		artment of artificate of			giene Reg. No.	00 32889				
ysician Medical	1. Decedent's Nama (First, Middle, Last Nathan	2. Data of Death September 29, 2000 3. Tima of Death 11:45pt										
aminer eral	4a Facility Name (If not institution, giva Holy Cross Hospi  5. Social Security Number 085-10-7949 6. Se	tal	yrs. last birthday Yrs.	) If Under 1 Yaar Months Days	Silver :	s. 8. Date of Bir n. (Month, Da	Montg					
-	Usual Residence of Decedent  10a. Slata 10b. County		c. City, Town or L	ocation		praren.	2917171	10d. Insida City Limits				
any injury or other traumatic avent, the Medical Exemples must be nothed as page.  To Be Completed by Funeral Director	Maryland Montgome	ry	Wheato	n 10f. Zip Code			10g. Citizen of V	1 ☐ Yas 2 ☐ No Vhat Country?				
eral Di	10859 Bucknell D	rive	- 11.0 Jan	20902		(Carata Van an Na	United	States - Amarican Indian,				
by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces? 1 ∑ Yas 2 ☐ No If Yes, Giva	WII	Was Decedent of If Yes, specify Cut  1□ Yes 2☑ No	oan, Mexican, Pus	into Rican, atc.)	Blac	lack, White, atc.				
Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ccation le completed) College (1-4or 5+) 5+	(Give	dent's Usual Occu a kind of work done DO NOT use retin	during most of w	orking	Small B	usinass/Industry usiness stration				
200	17. Father's Nama (First, Middle, Last)  Jacob Weiss			Sarah 1	Rothman							
	19a. Informant's Name/Relationship (7) Hilda Weiss / Wit 20a. Mathod of Disposition	fe 2	10859 0b. Place of Disp	ing Addrass (Stree Bucknell osition (Name of amatory or other pla	l Drive,		MD 209					
	1 Donation 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		Judean M	emorial (	Gardens ass of Facility	10/02/00		y, MD				
	Danzansky Goldberg Memorial Chapels, Inc 1170 Rockville Pike, Rockville, MD 20852  23a. Parti. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hour hadren shock or hour hadren shock or hour hadren shock or hour hadren. Interval Between Interval Between											
dical Examiner	Immediata Cause (Final diseasa or condition resulting in death)	Respirat	tory arr	est				Onsat and Death				
	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying	b	to (or as a conse	quence of):								
	Cause (Disease or injury that initiated events resulting in death) Last	cDue		9.5								
	Part II. Other significant conditions con Congestive heart		23b. Did tobacco use contribute to the cause of									
			24a. Was	24b. Wara autopsy tindings available prior to complation of causa of death?								
a completed	25. Was case refarred to medical			-	OC Bloom of D		Yas 2 No	1 ☐ Yas 2 ☐ No				
To Be	ayaminer?	lospital: 1 Inpatient 28a. Data of Injury	2 ER/Outpatie		eath (Check only ona)  Homa 5 Rasidence 8 Othar (Specify)							
Certification:	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Data of Injury (Month, Day Year)  28b. Tima of Injury M 28c. Injury at Work? 1 Yas 2 No						28d. Describe how injury occurred  28f. Location (Street and Number or Rural Routa Number, City or Town, State)					
edical C		sician: To the best of my ner: On the basis of axa and manner stated.										
Me	290. Signature and title of certifier  30. Nama and address of person who or	Plan	el u	7 D5226	se number			d (Month, Day, Year) er 29, 2000				
	Alan Segal, MD  31. Data filed (Month, Day, Year)		igo Circ	le, Silve	er Spring	g, MD 209	006					



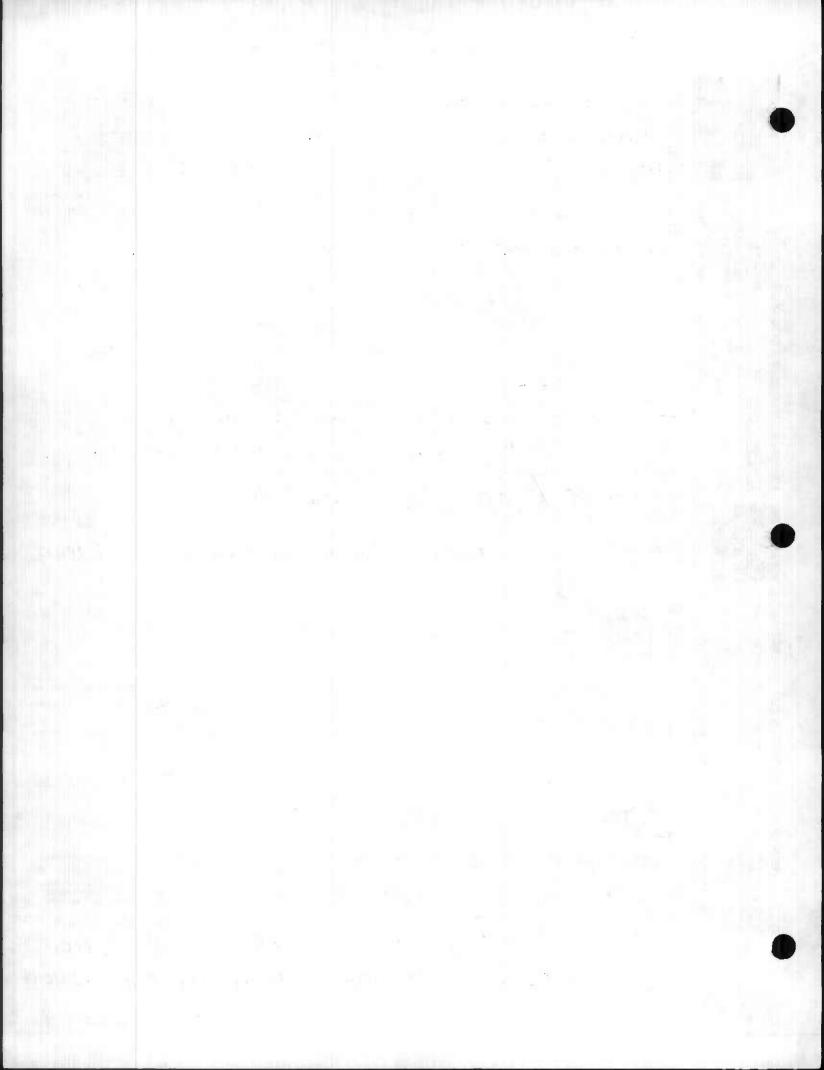
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** E. LAWRENCE WATKINS SEPT. 30, 2000 10:30 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oasys Eldercare Columbia HOWARD | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | July 12, 1922 5. Sociel Security Number 6 Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 100 M 2 F Yrs. 214-18-1681 Director Maryland Usuat Residence of Decedent worls 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ral', or items 23s or 28s-f show Examiner must be notified at XYes 2 □ No Director MD Howard Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9950 Guilford Road, #106 20794 U.S.A. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after o Department of Health and Mental hygiene. Important: if item 27 is marked other than "natural, or item any injury or other traumatic avant, tra Wederal Emminer 1 Never Merried 2 Merried 1 XYes 2 No If Yes, Give Yeer or Dates: Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black à 45-46 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) 7th Cotlege (1-4or 5+) Laborer Construction 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Lawrence Watkins Annie S. Holland 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 7466 Oakland Mills Rd., Columbia, MD 21046 John Myers, Jr. (Brother) Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from State 10/6/00 Crownsville, MD Maryland Vet. Cem. 4 ☐ Donation 5 ☐ Other (Specify) Sture of Funeral Service Licenses 22. Name end Address of Fecility SNOWDEN FUNERAL HOME, P.A. 20850 ROCKVILLE, MD 23a. Pert1. Enter the disasshock, or heart faiture e, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Olo-YECTAL CANCER disease or condition resulting in death) Examiner Examiner The lew requires that the death certificate be executed the buriel-transit Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or trijury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 88 signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1□ Yes 25 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings evailable prior to 24a. Was an autopsy parformed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 45 Norsing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes No this funeral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Aftar 5 Pending investigation Naturat 2 Accident after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homlcide 24 hours a Hospital \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner es stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier within 24 hor To the Fune completely fi (Check only ţ, 29d Date signed (Month, Day, Year) 29b. Signeture and title of certifier 10 evaler MU 3 30. Neme and address of person who expeleted cause of death (Item 23a) (Type, Print) 11065 Little Patuxent Pky Columbia. NICHOLAS H Koutrelakos MD 31. Date filed (Month, Dey, Yeer) 32. Registrer's Signeture State

DHMH t6 Rev 6/95

Registrar

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State of Maryland / Department of Health and Mental Hygiene

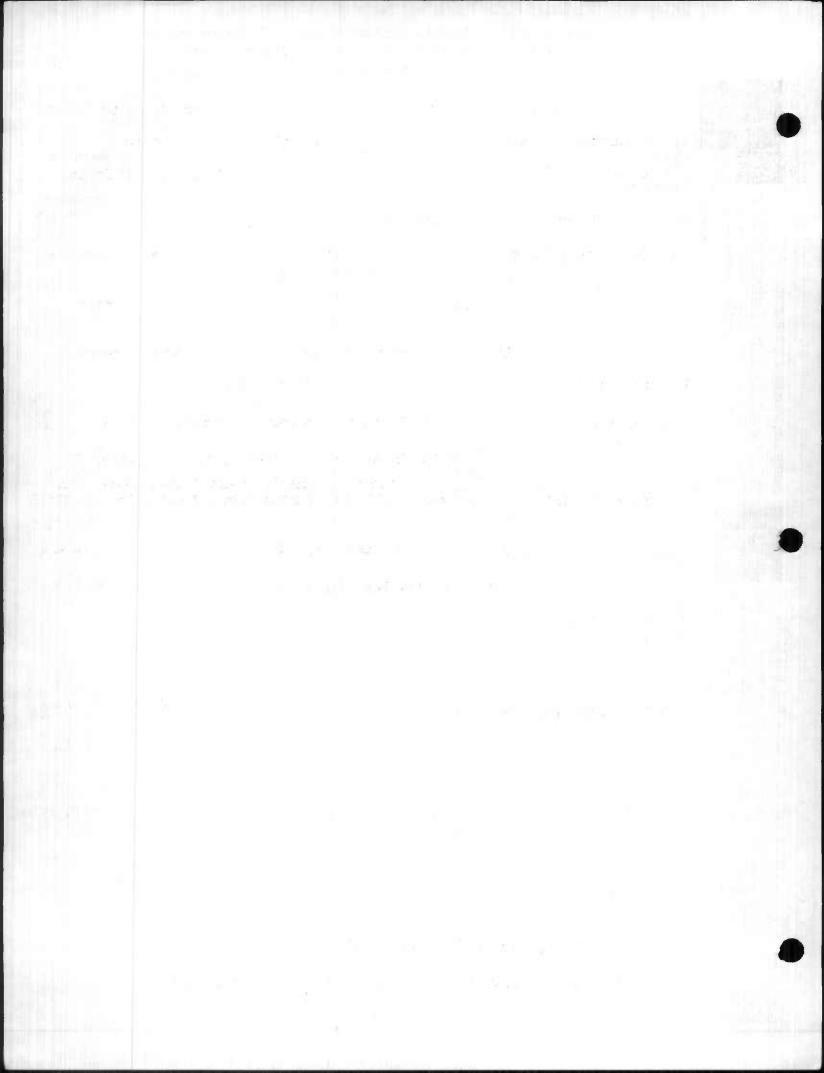
Certificate of Death

00 32891

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	Physic /Medi		Decedent's Nen	ne (First, Middle, L Wa	ast) 11ace R	. Win	kler					2. Dete of De Month Octol	Dey	Yaer 2000	3. Time of Death 7:00am
	Exami		4a. Feclity Neme	(If not institution, g	ive street end n	umber)				4b. City, To	wn, or Loc	cation of Deet	- 4		
		Ш		terfowl '	Terrace					Colu			How	vard	
	Funeral Director		5. Social Security 577 40 5		Sex 1⊠M 2□F	7. Aga (Ir 83	yrs. lest birth	rs.	Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, De Sept	th ey, Yeer) 3, 1917	9. Birthpi Count Illi	aca (State or Foreign try) NOIS
	P .		Usual Residence												
	Marylar H show	tor	MD	10b. County  Howard	đ	10	c. City, Town Colt						10d. Inside City Lin 1 ☐ Yes 2 ☐		
	r 28	Director	10e. Street end Nu	ımber					10f. Zip Code				10g. Citizen of	Whet Coun	try?
	h wit	a D	5020 Lak	e Circle	Court				21044				Unite	d Sta	tes
	deed deed	Funeral	11. Maritel Status		12. Was De Armed F	cedent Ever	In U,S.	13. W	as Decedent of H	lispanic Orl	gin? (Spec	cify Yas or No		ce - America	an Indian,
2	n 72 hours after deeth with the Maryland "netural", or Items 23a or 28a-f show solical Examinet must be notified at	by	111111111111111111111111111111111111111	ried 2 <mark>%</mark> Merried 4 □ Div <i>o</i> rced	1 X Yas	2□No Sive Detas:19	43-46	J.S. 13. Was Decedent of HispanIc Origin? (S If Yes, specify Cuban, Mexican, Puert				erto Rican, etc.)  Bleck, \ Specify:			ite
	72 ho	ted	(2)	15. Decedent's E	Education		16a. D	Decade	ent's Usuel Occup	etion			16b. Kind of B		
21212-0020	within the	Completed	(Spe Elementery/Sec	ondary (0-12)	College	College (1-4or 5+)		16a. Decadent's Usuel Occupetion (Give kind of work done during most of life. DO NOT use retired)  Research Analyst				al Government			
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man years	Mental Merked of arked of attic eve	To Be	Alpherd	Winkler						Elsi	e Ste	elle			
	2 should and Men is marke	1	da	lame/Reletionship	(Type, Print)		19b.	Meilina	Address (Street				er. City or Town	Stete Zip	Code)
	d the			kler/Wife					Lake Cir						
)	s 1 and 2 should f Health and Mer tam 27 is marke other traumatic		20e. Method of Dis			2			ition (Name of etory or other plea		ourt	Dete	20c. Location		
Carrier Co.	90 = 10		4 Donetion	Cremetion 3       5 □ Other (Special)	ify)	n State	Metro	Cre	ematory			L1-2000	) Catons	ville	, MD
3	permit. Pa Depertmer Important: any Injury once.		21. Signeture of F	uneral Service Lice	ensee	MO10	2. 12.	Ha	Name end Addre	Witzk	e's E				, Inc. MD 21043
	Ob i a i		23e. Pert1. Enter shock, or he	the diseese, or cor art feilure. List only	nplications thet y one ceuse on	caused the eech line.	death. Do no	ot enter	r tha mode of dylr	ng, such as	cardiec or	r respiretory a	rrest,	CILY,	Approximete Intervel Batween Onset end Deeth
	Physician /Medical Examiner		Immediete Ceuse disaese or conditi resulting in deeth)	on	· CA	heDi.	AC /	4 R	RHYT	I+Π 1,	A			[	TINUTES
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	certificate be executed nding physician end use as the burial-transit	n/Medicai	resulting in deeth) Lest  Due to (or es e consequenca of):										į		
5	th certing ending r use a	an/M		•	d		~ · · · · · · · · · · · · · · · · · · ·							<u> </u>	
	death he atte	sici	Part II. Other aigni	ficant conditiona	contributing to	death but no	ot resulting in t	the unc	derlying cause giv	en in Pert I		23b. Did	tobacco uee co	entribute to	the cause of death?
	requires thet the death een signed by the atter hould be detached for i	by Physicia	ALZ	HEIME	ies D	1515/	KE.					10	Yes 2 No	3 Prob	ably 4 Unknown
10000	- 00	Completed b								-			en eutopsy ormed?	cor	re autopsy findings iilabla prior to npletion of cause leeth?
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	ician: The	BeC	25. Wes case refe	rred to medical						28. Piece	of Death	(Check only			
	Physician: this certific ral director,	0	exeminer?	No.	Hospital:	] Inpatient	2□ ER/Outr	patiant	3□ DOA Oth	or:				ner (Snecifi	asst.livi
	유 유 교	ation: T	27. Manner of Dea 1 X Naturel 2 ☐ Accident	ter of Death    See Dete of Injury   28b. Time of Injury   28b. Ti									ASSC. IIVII		
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicida 4 Homicide  6 Could not be determined  28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)  28f. Location (Street and Number or City or Town, Stete)							ber or Rura	l Route Number,				
1	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	edicai C	29a. Certifier (Check only one)	1X Certifying P 2  Madical Exa	miner: On the I	e best of my basis of exa nner steted.	y knowledge, mination and/	death o	occurred et the tirestigetion, in my o	ne, dete en pinion, dea	d plece, e	nd due to the d et the time,	ceuse(s) end modate end placa,	enner es st end due to	eted. the ceuse(s)
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Registrar

OCT 10 2000



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#28a,b,f perPHYG787 9/21/2000 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day Whi HingTon 1224 Jul 4 Sbury ATHANIE 31 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. Hours Min. 5. Sociat Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 15 M 2□ F Months Days 29 212-14-4349 Yrs. MD 11-15-10 Usual Residence of Decedent 10h. County 10a State 10c. City, Town or Location 10d. Inside City Limits Micomico 1 Nes 2 No MD Alisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 21801 Ko binson 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Merital Status 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Specify. 35 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DEER'S HEND HOSP. 124 ATTENDANT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Whitting-Ton 4RZAH WhittingTon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Placa of Disposition (Name of cametery, crematory or other place) Alisbury MD 21804 DOR'S DonahuE - DAUGHER 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8-4-00 KINGSTON, MD Cometery FAmily 22. Name and Address of Facility Arthony 8. Walp Funeral Homo 30439 Hampdon Ave. Princess Ar enter the mode of dying, such es cardiac or respiratory arrest, 21, Signature of Funeral Service Licenses 30439 Hampdon MO 21853 Anne, 23e. Part1. Enter the disease of complications that caused the deeth. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yae 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings evailable prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1) Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time ot tnjury 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No falls at home 7/24/2000 UNK 2 Accident

ettending physician and for use as the burial-tran Box 68760 The law requires that the death Division of Vital Records, P.O. page 2 s this certificate After deeth.

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ours effer deeth. earel Director: A filled in by the fo within 24 hours or To the Funerel Completaly filled

Physician/Medical Examiner

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Completed

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edical Certification:

**Physician** 

Examiner

**Funeral** 

**Director** 

28a-f show

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7 is marked other than "natural", or items 23s or 28s-f sho traumstic event, the Medical Examinar must be notified at

11-15-10

P4-4349

Maryland 21215-0020

Baltimore,

Peges 1 and 2 should be nent of Health and Mental

Mem 27

permit. Peges Department of Important: If Its any Injury or o

Physic ian Medical

E-amina

/Medical

1 Yes 2 No 27. Manner of Death

3 Suicide 4 Homicide

6 Could not be determined

28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify)

Home

28t. Location (Street and Number or Rural Route Number, City or Town, State) 501 Robinson ST, Salisbury, Md

Delmar MD 21875

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and menner steted. 29b. Signature and the of certifier

29a. Certifier

29c. License number D0054122 DME

29d. Dete signed (Month, Day, Year)

address of person who completed cause of death (ttem 23a) (Type, Print) Alon MD

AUG 0 7 2000

MD

DAVIS 31. Date tiled (Month, Day, Year)

DME 32. Registrar's Signature

Registrar

State

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 32893 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Data of Death **Physician** Adams Dusie 8:00 pm 10 10 2000 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner of Hospital Maryland Baltimore 8. Date of Birth (Month, Day, Year) Mar 19, 19 5. Social Security Number If Undar 1 Yaar If Under 24 Hrs. 7. Aga (In yrs. last birthday) 9. Birthplace (Stata on Foreign Country) UNK **Funeral** 1□M 2₩ F Months Days Hours 218-26-9415 80 **Director** Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23s or 25s-f show eminer, must be notified at MD Baltimore YE Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1217 W. Favette Street 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No It Yas, specify Cuban, Mexican, Puerto Rican, atc.) unk 14. Raca - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Saltimore, Maryland 21215-0020 by 3 Widowed 4 Divorced black Completed 16b. Kind of Business/Industry unk 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk Pages 1 and 2 about the filed within inent of Health and Merital Hygiens, ant, if hern 27 is marked other than 1/4 bry or other trauments event, the Med Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) University of MD Hospital 22 S. Greene Street Baltimore, MD 20b. Pleca of Disposition (Nama of cemetery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stata Department of important; if it 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🖾 Other (Specify) in state 21. Signature of Funeral Servica Licensee Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street nuer Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock or heer failure. List only one cause on each line. Approximate Interval Betwe Onset and Death Physician /Medical Immediate Cause (Final disaasa or condition resulting in death) Examiner Physician/Medical Examiner neumoni The law requires that the death certificate be executed Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting In death) Last Box 68760, Due to (or as a consequence of): P.0. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, by 24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to completion of cause of death? Medical Certification: To Be Completed page 2 certificate hes 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred Injury at Work? 5 Pending Investigation 1 Maturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide 1 Contifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, end due to the cause(s) and manner stated. 29e. Certifier (Check only 29b. Signature and tille of cortifier 29c. License number 29d. Date signed (Month, Day, Year) P13374 2000

State Registrar

OCT 1 8 2000 **DHMH 16 Rev 6/95** 

31. Date tiled (Month, Day, Year)

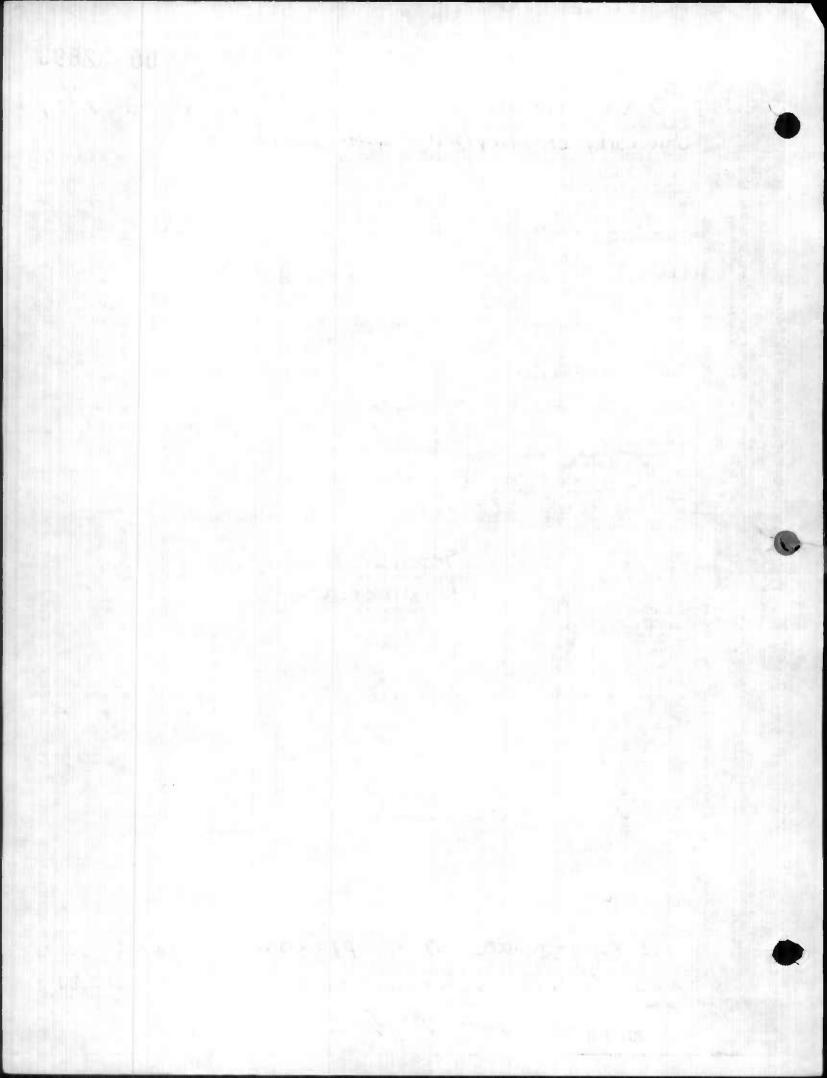
32. Registrar's Signature

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Smith MD

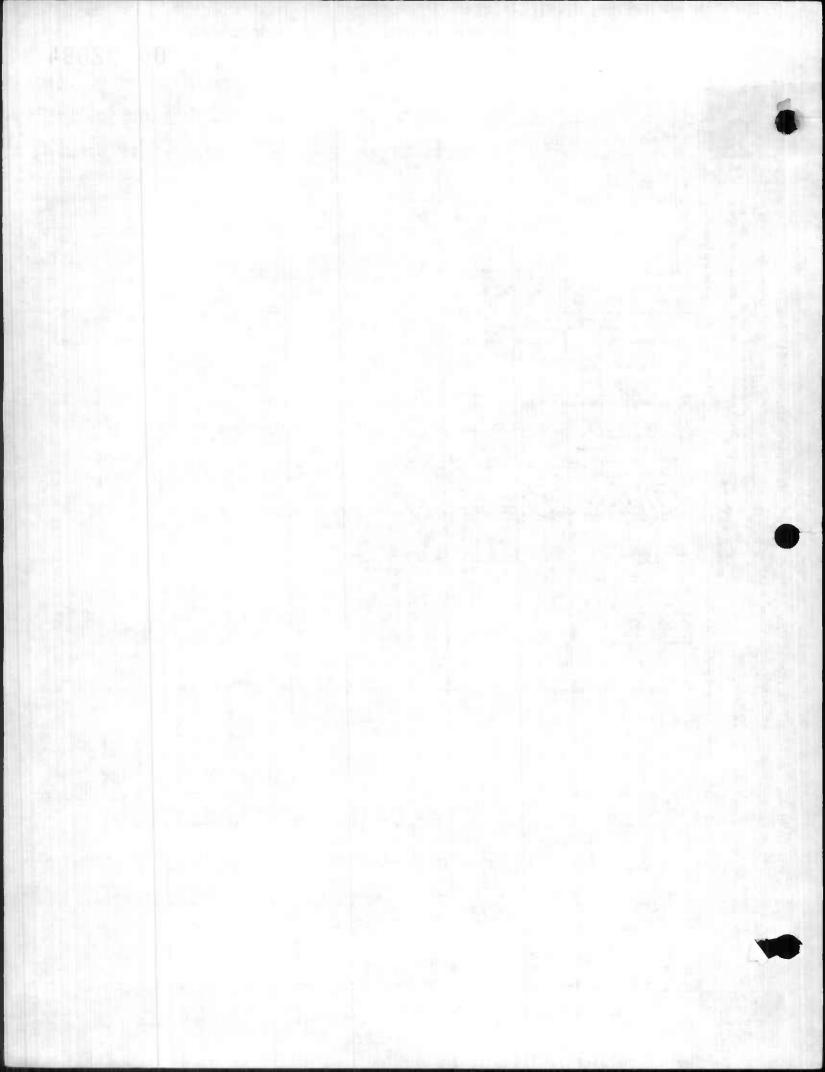
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22 s. Greene St. Baltimore, MD



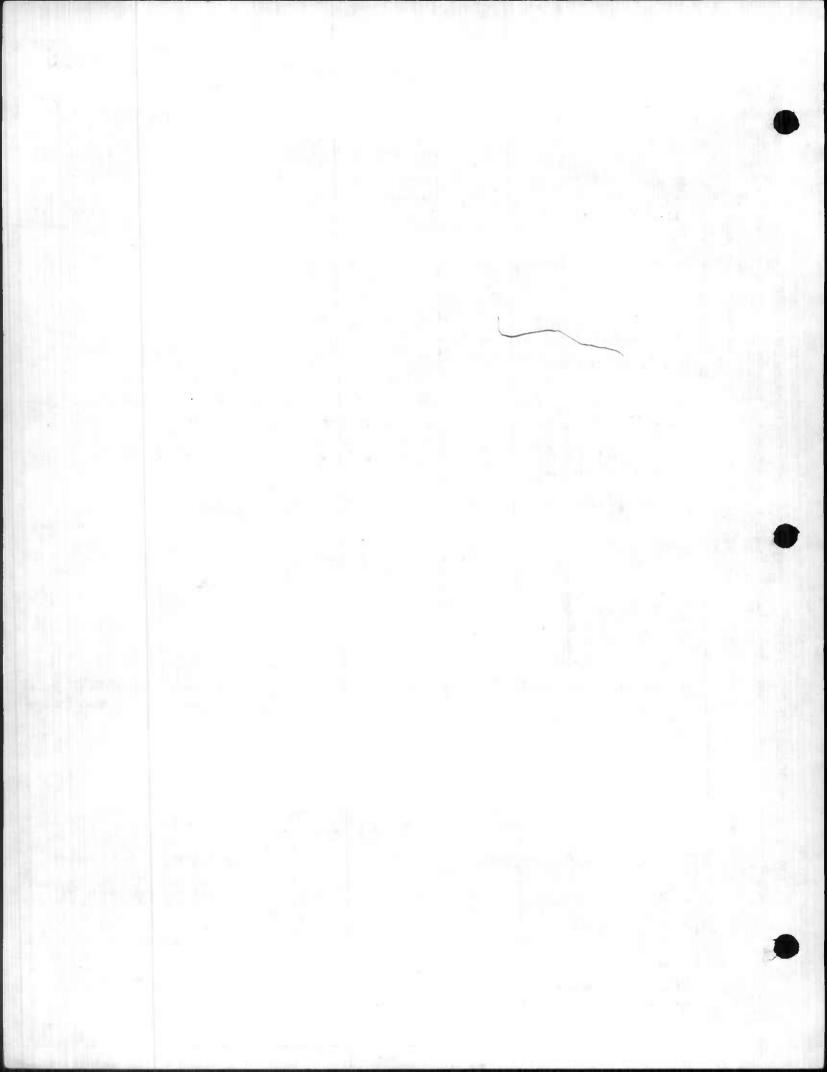
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	Decedent's Name (First, Middle, L.						-	2. Date of Dea			3. Time of Death		
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/Medical	An English Name (Mant Institution of					4b. City, To	wn, or Lo	OCTOBE ocation of Death		000 of Death	2151 pm		
Examiner	Johns Hopkins					Balt	imor	~	N/A				
Funeral			Age (In yrs. las		der 1 Year	If Under	24 Hrs.	8. Date of Birti (Month, De)		9. Birth	place (Stete or Foreign		
Director	216-78-7424	1 M 2□ F	30	Yrs. Mont	hs Days	Hours	Min.	1-7-19	70	Balti	nore, Maryland		
	Usuel Residence of Decedent												
show	10a. Stele 10b. County	,	10c. City,	Town or Location							10d. Inside City Limits		
the Maryla 28a-f shor notified at	MD	n/a			Ва	ltimo	re		1 Sq Yes 2 □ No				
1 2 4 5 E	10e. Street and Number			10f.	Zip Code				10g. Citizen of	What Cou	ntry?		
of the state of th	2006 Bank Stree					231				USA			
ler dea	11. Marital Status	12. Was Deceder Armed Forces	57	13. Was De If Yes, s	ecedent of F specify Cub	lispenic Ori an, Mexicar	igin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	14. Rad Bla	e - Americk, White,	can indien, etc.		
S athe		If Yes, Give		1 □ Yes	s 25 No	Specify:			Specif	v: Wh	ite		
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Marylar d 2 should but and Menta 7 is marked treumetic even	19a. informent's Neme/Relationship		oor	19b. Melling Addr	ress (Street				r. City or Town	Stete, Zij	Code)		
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	20a. Method of Disposition		20b. Plac	ce of Disposition (	Neme of	ilu st		Date	20c. Location				
	1 Burial 2 Cremation 3		0		or other ple	ce)	10	/20/2000	Doltimon	Mon	b ma fee		
Baltimore, permit. Pages 1 as Department of Hee Important: If item is once.	4 □ Donation 5 □ Other (Special Service Lie	•	GLE	enmount 22 Name	and Addre	ss of Facili							
Ball Ball Ball Ball Ball Ball Ball Ball	1 h	h2	/				JOS				eral Home		
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/Medical Examiner per per per per per per per per per p	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. HYPERT	Due to (or a	CARDIOMYOPA is a consequenca	of):								
3760, ate be assecute by sician and he burial-transfer in the burial	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
3 st st 3	resulting in death) Last	С.	Due to (or es e consequence of):										
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Box 6/6 seth certific attending portion of for use as:		d											
P.O. BOX 61 Let the death certificate by the attending pletached for use as: Physician/Mex	Part II. Other significant conditions	contributing to death	but not result	ing in the underlying	l.	23b. Did tobacco use contribute to the cause of death?							
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The law requires to the law requires to the has been signed page 2 should be completed by									an autopsy med?	81	Vere autopsy findings vailable prior to completion of cause		
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	2 Accident investigati			М	1	Yes 2	No						
DIVISI To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	3 ☐ Suicide 6 ☐ Could not determine	28e. Place of I	injury - At hom etc. (Specify)	e, farm, street, fac	ctory, office			28f. Location (S		ber or Rui	rei Route Number,		
Diptal or ours after Direction in filled in													
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To the Hos within 24 h To the Fun completely		and manner	stated.		00a 1 iaaa				20d Data siza	nd /Month	Day Yearl		
or with	29b. Signature and title of certifier	00			29c. License number				29d. Date signed (Month, Dey, Year)				
	7 Canton	Comp			0.0	C.M.E	•		Octobe	r 1/,	2000		
	30. Name and address of person wh	o completed cause of	death (Item 2										
	31. Date filed (Month, Dey, Year)	INV	1		Stree	t, Ba	ltim	ore, Ma	ryland	21201			
State Registrar	OCT 18	2000	Strar's Signatu		Spa	W. 1							
negistiai	9011			1 .	FURNING	112/							



State of Maryland / Department of Health and Mental Hygiene 0 32895

			C	ertifica	te of	Death		Re	ig. No.	3	2090
Physician	1. Decedent's Name (First, Middle, L	ast)						2. Date of Death Month	Day	Year	3. Time of Death
Physiciar /Medica	D	Bunjon						October		000	6 PM
Examine	to Contibutions // not institution or	ive street and number)						ation of Death	4c. County	of Death	+
1 L	Genesis- Hamilt		and the seat of the sea	N Hode	er 1 Year		imor			N/A	
Funeral Director		Sex 7. Age (In 1	yrs. last birthda Yrs.	Months		Hours	Min.	8. Dete of Birth (Month, Day, March 29	Year) 9,1918		place (Stete or Foreign pland
Mend Mend	10a, State 10b. County	100	. City, Town or	Location						1	Od. Inside City Limits
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						21211	18		US	A	
020 ura etter	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 25 No If Yes, Give Year or Dates:	ar in U,S. 13. Was Deceden If Yes, specify 1 ☐ Yes 2 €			ont of Hispanic Origin? (Specify Yes or No by Cuban, Mexican, Puerto Rican, etc.)  No Specify:			o- 14. Race - American In Black, White, etc.  Specify: White		etc.
vithin 72 hours one.	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation rade completed)	16a. De	cedent's Usive kind of w	ual Occu	pation during most d)	of workin	g 1	16b. Kind of Bu	isinass/Inc	dustry
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d 2 d		e)	1 100	OK DI	ider	18 Mother	r's Nama	(First, Middle, M			acturer
and de di	Tosoph Runion	*				Ber		Larosa	alden damem	9)	
Maryland d2 should be file th end Mental Hy 7 is marked other traumatic event	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Addres	s (Stree	t and Numbe	or or Rural	Route Number,	City or Town.	Stete, Zip	Code)
Mary and 2		rother)	428	9 Fali	le Ro	nad B	altir	nore, Ma	breland	2121	11
of He standard	20a. Method of Disposition	2	0b. Place of Dis	position /N	ame of		1		Oc. Location -		
Pege mi: H my or	1 Sp Burial 2 ☐ Cremetion 3 [ 4 ☐ Donetion 5 ☐ Other (Spec						al 10	0/17/00	Cockey	sville,Md	
Baltimore, Maryland 21215 permit. Peges 1 end 2 should be filed within 7/ Department of Health and Mental Hygiens. Important: If Hem 27 is marked other than "ny any injury or other traumatic evant, the Med page.	21. Signature of Funeral Service Lice	)(X/	,)	Puran	Hor	ess of Fecility	ite I	Funeral	Home,	Inc.	21211
-	23a. Part1. Enter the disease, or cor shock, or Mart failure. List only	nplications that caused the	death. Do not	3631_I	alls	Road	Ba l	timore,	Maryl	and	Approximate
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oerificate be executed ding physician and ise of the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or In)ury c.									
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Vital In biclen: The certificate inector, page						26 Diace	of Death	(Check only one		' -	1165 2010
	examiner?	Hospital: 1 Inpatient	2 ER/Outpat	ient 3 C	OA OE	hor		e 5 ☐ Reside		er (Specifi	V)
O & 5 2		28a. Date of Injury (Month, Day Yea	the same of the sa	of		ry at		8d. Describe ho			,,
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Division of attending Practice Attended in by the tuner Contilication:	3 Suicide 6 Could not 4 Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, pecify)	street, facto	ry, office		2	81. Location (Str City or Town		er or Rura	il Route Number,
Hoapi A hou tely fill	29a. Certifier 12 Certifying M (Check only 2 Medical Exa	hydicion: To the best of my miner. On the basis of exa- and magnin stated									
To the state of th	29b. Signature and title-of contiliur	/ //		2	c. Licen	se number	6-11	29	d. Date signe	d (Month,	Day, Year)
10/	17.//2	1			1)	454	75		101	7/0	70
1/1	30. Name and address of person who	completed cause of death	(Item 23s) (Typ	e, Print)		10 1	11	, ,		113	.0
1 40	Dr Mohemmad	Rahnama	- Fra	intli	NS	quan	e He	Spital	Bal	to. N	10
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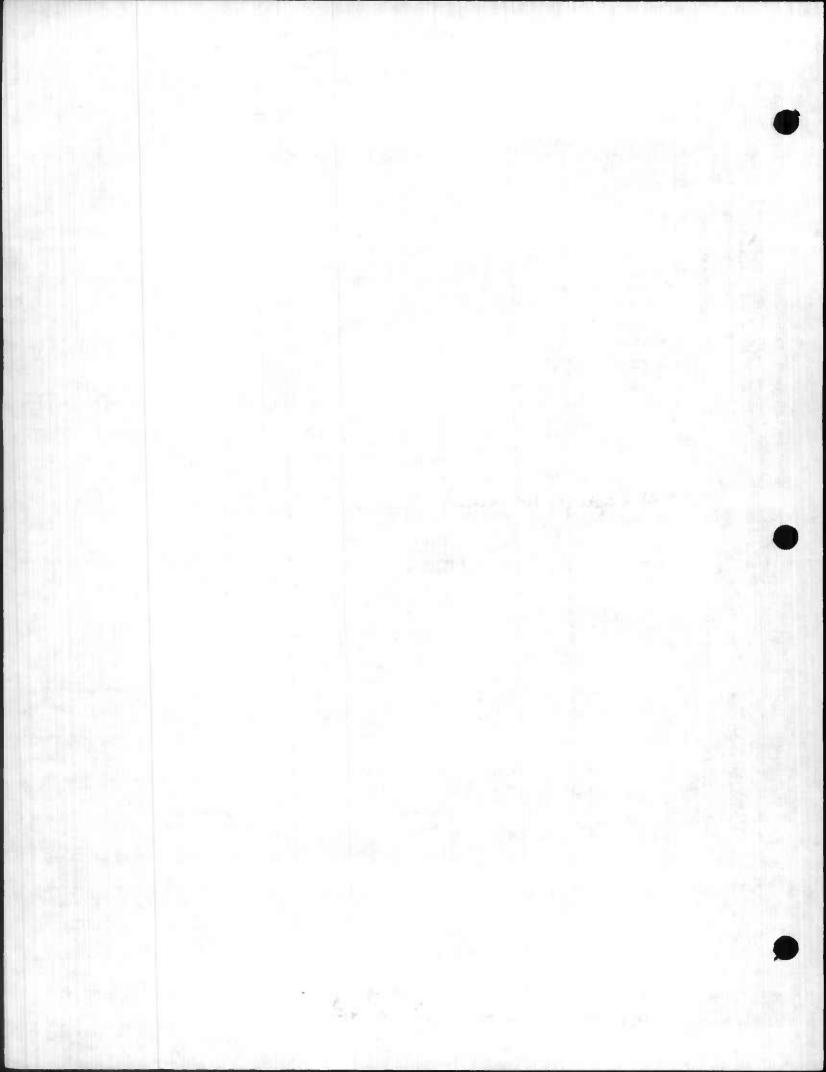


State of Maryland / Department of Health and Mental Hygiene 00 22000

		,	Cei	rtificate of	f Death	R	eg. No.	32896				
Dhualaian	1. Decedent's Nama (First, Middle, Lat	st)	EX.			2. Data of Dear Month	th	3. Tima of Death				
Physician /Medical Examiner	Michael		Booker			Oct.	15, 2	000 8:00pm				
	4a Facility Nama (If not Institution, give				4b. City, Town, or	Location of Death						
	4 Barnacle Co		s. last birthday)	If Under 1 Yes	Essex ar If Undar 24 Hrs.	8. Data of Birth		imore				
Funeral Director	259-98-8010	DM 2□F 41	Yrs.	Months Day		01-02	2-58	Birthplace (Stata or Foraign Country) GA				
and	Usual Rasidance of Decedent  10a. Stata 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits				
Mary February to	MD Baltim	ore	Essex					1 ☐ Yas 2€No				
vith the Mar or 28a-f el be notified Director	10e. Street end Number			10f. Zip Coda		1	0g. Citizen of Wh	at Country?				
th wit	4 Barnacle Cou	rt		212	20		USA					
fler deeth v free must free must	11. Marital Status	12. Was Decedant Evar in Armed Forcas?	U,S. 13.	Was Decedant of	Hispanic Origin? (Suban, Mexican, Puart	pecify Yas or No- o Rican, atc.)		Amarican Indian, Whita, atc.				
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2 should land Menis marked	19a. Informant's Name/Ralationship		19b. Mailir	ng Addrass (Stre								
and 2	Inell Booke											
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parmit. Pa Department important: any Injury	21. Signature of Funaral Sarvice Licansee 22. Nama and Addrass of Facility Baltimore, Maryla											
E S E S E	WM.C.March FH 4300 Wabash Avenue											
	23a. Part1. Enter tha diseesa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or respiretory arrest, shock, or haart failura. List only ona causa on aach lina.  Approximately a cardiac or respiretory arrest, interval interval interval.											
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requir should should						24a. Was a perior		24b. Wara autopsy findings available prior to completion of causa of death?				
The lew page 2 page 2						1 🗆 Y	as 2 No	1 ☐ Yas 2 ☐ No				
yaiclen: The secretificata director, pag	25. Was cesa ratarred to medical axamiper?					ath (Check only or	(e)					
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Attending Port death.  Sector: After the by the funeral iffcation:	27. Mannar of Death  1	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	W	jury at ∤ork? □ Yas 2 □ No	28d. Dascribe how injury occurred						
Popular P	3 ☐ Suicida 6 ☐ Could not be datamined	28a. Placa of Injury - At building, atc. (Spec	6	28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta)								
Pa Hospital 24 hours Funeral plately filled edical C		yelclan: To the best of my kr niner: On the basis of examin and manner stated.										
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W/	Charles	+01 m	11001	MAD	0938.	3 /	hopa	17.2mm				
1/1/	30. Nama and addrass of person who	completed cause of daeth (Ite	em 23a) (Type,	Print)		15	Apt.	408				
00.10	Dr. Charles O'	Donnell Har	bor He	ouse Hi	ighrise	Village	of Cro	oss Keys				
State	31. Data filed (Month, Day, Year)	32 Ragistrar's Sign	nature A	800 3								

DHMH 16 Rev 6/95

**ORIGINAL** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Amended Item#24a,25,26,27,29a perPHYG788 101/8/2000 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Day **Physician** AUGUST 27, 2000 8:30 PM KATHRYN F. BOTELER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 41960 White Point Beach Road Leonard town

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year
Dec 31, 19 Leonardtown St. Marys If Under 1 Yeer 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 N F Days Months Yrs. 214-03-0535 89 Director Usual Residence of Decedent the Maryland r 28a-f show 10e State 10h County 10c. City. Town or Location 10d. Inside City Limits MD St. Marys 1 Yes 2 No Leonardtown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with "naturel", or items 23s or 20650 USA 41960 White Point Beach Road Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.

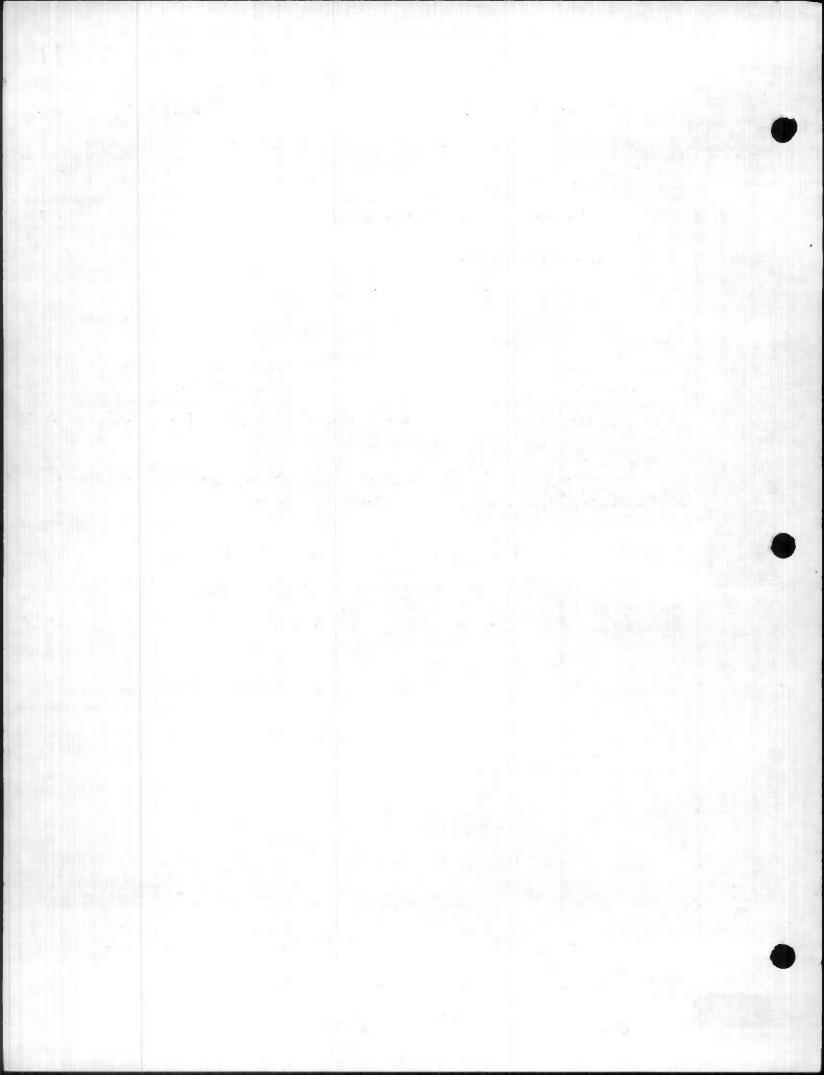
The marked other than "naturel, or items 23 may or other traumatic event, the Medical Experient man 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes. 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, spacify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Biack, White, etc. 1 ☐ Never Married 2 ☐ Married white 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 If Yes, Give Year or Dates: by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) none housewife 12 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Be Daisey O. Brown Milton M. Clark 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 20650 Joyce Tucker/daughter 41960 White Point Beach Rd Leonardtown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlal 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Segvice Licensee Joseph B Van Sant 22 Name and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201 Part I enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximeta Interval Between Onset end Death Physician /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Examiner aw requires that the death certificate be executed physician and the burial-transi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or for use as t signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown p 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy peen completion of cause of death? page 2 has 1 Yes 2 X No 1 Yes 2 No certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifics director, Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidenca 6 Other (Specify) 2 1 Yes 21 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral Certification: 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28e. Dete of injury (Month, Dey Year) 28c. Injury et Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 5 24 hours after re Funeral Direction bletely filled in b 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and megner stated. To the Hospi within 24 hou To the Funer completely fil Medical 29e. Certifier 29b. Signeture and little of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 30. Name and address of person d cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

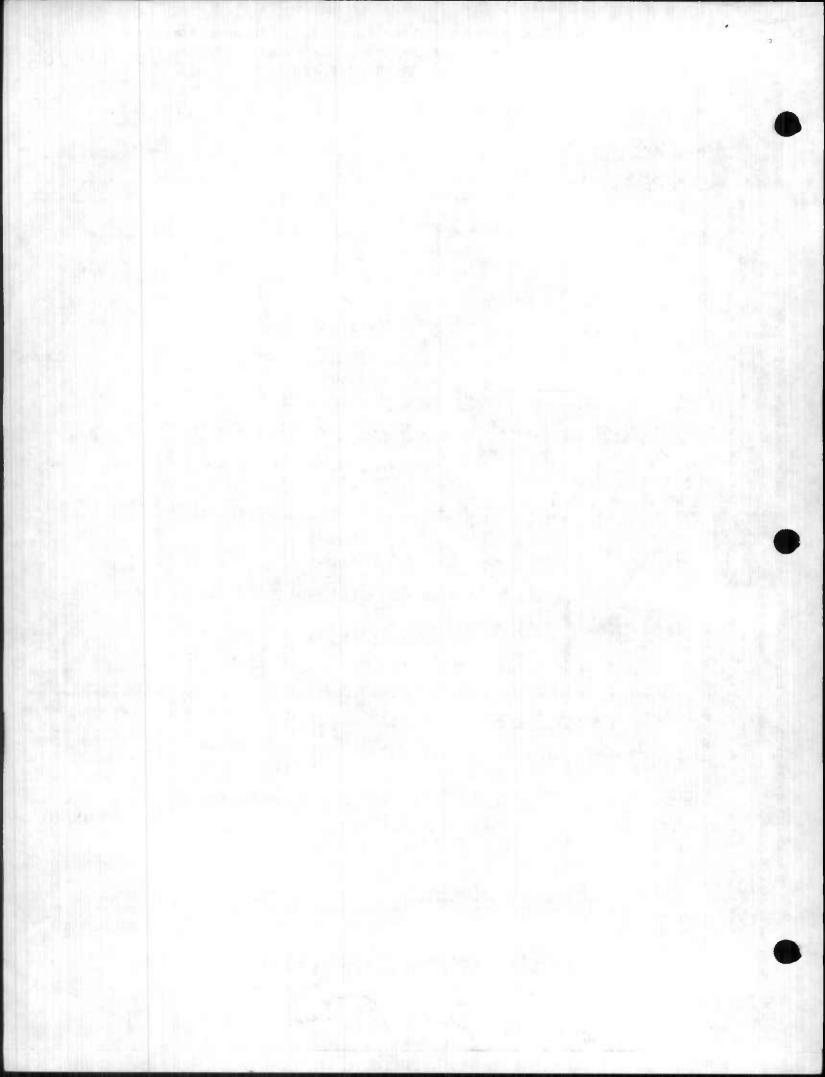
State Registrar

OCT 1 8 2000 DHMH 16 Rev 6/95

32. Registrer's Signature



AMENDED Item	State of Maryland / Department of Health and 17 perFH, Item#23a per PhyG788 10/18/2000 EW Certificate of Death	Mental Hygiene 00 32898
Physician /Medical	1. Decedent's Name (First, Middle, Last)  A DERTH BALLANGER	2. Date of Death Month Day 5, Year 8 1 3DAM
Examiner  Funeral Director	5. Social Security Number Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  243-03-2500 1 M 29 F 80 Yrs.	
show	Usual Residence of Decedent  10a. Stata 10b. County 10c. City, Town or Location	10d. Inside City Limits
with the Maryland a or 28a-f show be notified	10e. Street and Number, 10f. Zip Code	10g. Citizen of What Country?
ter death theme 23 tree mus	11. Marital Status  12. Was Decedent Ever In U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 4 Divorced 1 Yes, Give Year or Dates:  1 Yes 2 No Specify:	Specify Yes or No- nto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: BA
2121 od within giene. or then	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondery (0-12)  College (1-4or 5+)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)	orking 16b. Kind of Business/Industry  Or Ken Cleaning Home  ome (First, Middle, Maiden Surname)
Baltimore, Maryland nemt. Pages 1 and 2 should be file apparatus of Health and Mental Hy apparatus of their traumatic event to high of other traumatic event to hear traumatic event	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of Factorian Alexandres)  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 200 Location - City or Town, State  10-13-200 Ownes  Aformes
Ba distant	21. Signature of Fureral Service Licensee  22. Name and Address of Facility  13 ETTS FUNCTION  23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardie shock, or heart failure. List only one cause on each line.	(C) 104110 110 12010
Box 68760, eath certificate be executed with certificate be executed attending physician and for use as the bunel-transit clan/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	MINAL
igned by the signed by the signed by the signed by the signed by Physic	Part II. Other agnificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contributs to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
Record The lew required to the second	Aggertism, ASCVD	24e. Wes an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No
ng Physic ther this couneral direction: To	examiner?  1	eath (Check only one)  Home 5 ☐ Residence 6 Nother (Specify) Hospice  28d. Describe how injury occurred
DIVIS	3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	281. Location (Street and Number or Rural Route Number, City or Town, Stete)
DIVISION C To the Hospital or Attending P within 24 hours effer death. To the Funeral Director: Affer t completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place of examination and/or investigation, in my opinion, death occurred at the time, date end place of examination and/or investigation, in my opinion, death occurred at the time, date end place of examination and/or investigation, in my opinion, death occurred at the time, date end place of examination and/or investigation, in my opinion, death occurred at the time, date end place of examination and/or investigation, in my opinion, death occurred at the time, date end place of examination and/or investigation, in my opinion, death occurred at the time, date end place of examination and/or investigation, in my opinion, death occurred at the time, date end place of examination and/or investigation, in my opinion, death occurred at the time, date end place of examination and/or investigation, in my opinion, death occurred at the time, date end place of examination and/or investigation, in my opinion, death occurred at the time, date end place of examination and/or investigation, in my opinion, death occurred at the end place of examination and occurred at the examination and occurred at the examination and occurred at the end place of examination at the end place of examin	
	30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)  MASA J Brown 34 Sr Paul  21 Date (March 200 Year)	10/6/D Place Swer 403 21202
State Registrar	31. Date filed (Month, Day, Year)  32. Registrar's Signature	



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** 1:00 pm Edna Bechtok 2000 October /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Roge m Homore Yokana 1801 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 20 F 217-05-9330 Yrs. Director December 17,1917 MANJANO Usual Residence of Decedent 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland tachoille 10e. Street and Number 10f Zip Code 10g. Citizen of Whet Country? "natural", or items 23a or Road ). S.A. 1801 Yokona 21234 Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indian, Biack, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced Inite Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Black: Decher 12 TYPIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental n and Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If Nem 27 Is marked any injury or other traumatic av page. Carolyn Rutledge Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tacholle John Bechtold - Hosbar mo 21234 20b. Place of Disposition.

Cometery, crematory or other place,

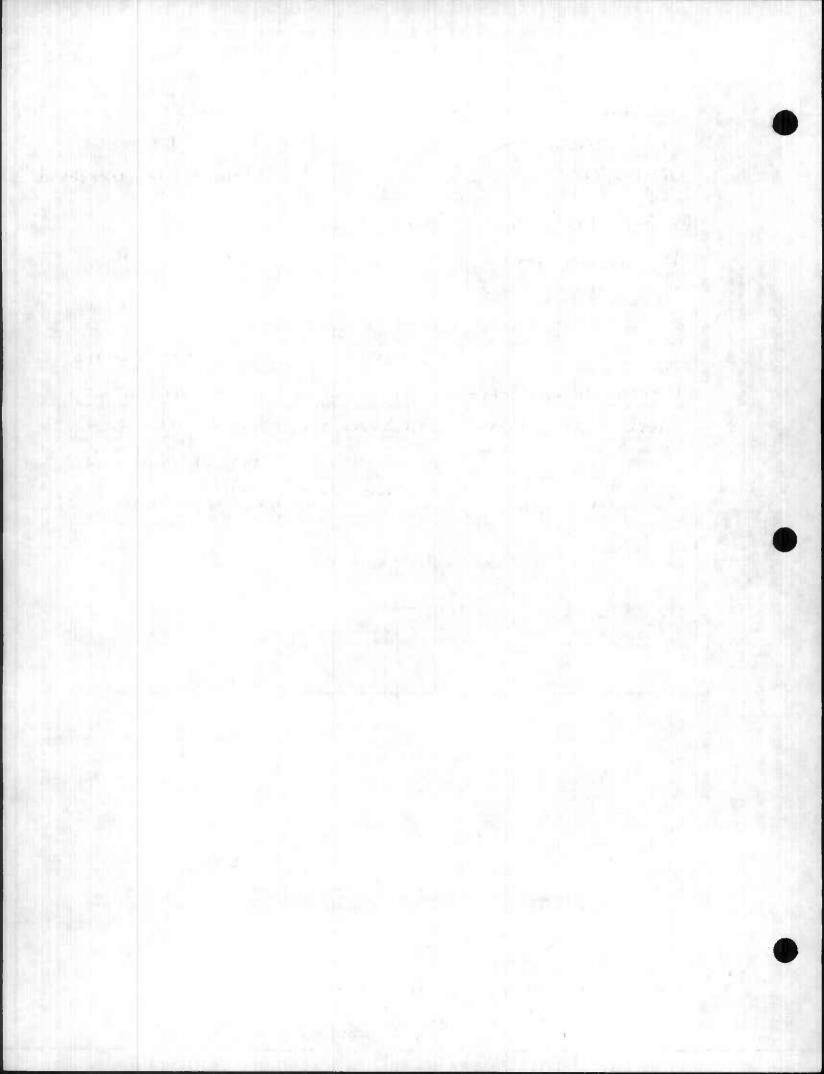
West I hopfy U.M. Ch. Como

22. Name and Address of Fecility

The record of 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 X Buriai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/17/00 White 21. Signeture of Funeral Service Licensee Examp Fineral Road Prochoille MD 21234 Thomas 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical Cardiac **Examiner** Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the bunal-trar Due to (or as a consequence of): P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Rhysema Division of Vital Records. Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy pital or Attending Physician: The law burs after death. eral Director: After this certificata has i filled in by the funeral director, page 2.3 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital
within 24 hours a
to the Funeral E
completely filled 1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. Medical 29a. Certifier 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signeture and title of cartille D 39297 10/16/00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2314 Enst Juppa Rond DR. Michael Ro 31. Dete filed (Month, Day, Year) OCT 18 State 2000 Registrar DHMH 16 Rev 6/95

**ORIGINAL** 



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Data of Death 1. Decedent's Name (First, Middle, Last) Physician Matthias W. OCTOBER 15 2000 11:55 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON
If Under 24 Hrs. BALTIMORE GREATER BALTIMORE MEDICAL CENTER If Undar 1 Yaar 9. Birthplace (State or Foreign 6. Sex ∫XM 2□F 7. Aga (In yrs. last birthday) **Funeral** Days Hours 215-20-9088 Usual Residence of Decedent Yrs. 16 1914 Director 119 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 21236 Funeral . Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Haca - American Black, White, etc. American Indian Evar in U.S. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 Yes 2000 Specify Specify: Why 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work dona during most of working Alife. DO, NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) linistr 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middla, Last) should be Ind Mental 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Royte Number, City or Town, Stete, Zip Code) Perry Hall If hem 27 h Saltimore, 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Definer (Specify) 2000 21. Signature of Furieral Service Licenses 22. Nama and Address of Facility Evans Funckal (23a: Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sligh as cardiac or respiratory arrest, shock, or heer feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical (ANDIDIASIS DISSEMINATED 1 WEEK Examiner Due to (or as a consequenca of): Physician/Medical Examiner Y WEEK CANDIDA CULITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequanca of): Box 68760 Due to (or as a consequence of): Part ff. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yee 2 No 3 Probably 4 Unknown ARTERY DISCASE, CHRONIC þ of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed RENAL INSUFFICIENCY CHRONI OBSTRUCTUE 1 Yes 2 ₹No 1 Yes 2 No PULMONARY DISEASE or Attending Physician: 25. Was case raferred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 28c. Injury at Work? 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred Division 1 Neturel 5 Pending after death. Director: Aft 1 Yes 2 No Invastigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, end due to the cause(s) and menner stated. 29a. Certifier within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signeture and thie of certifier 29c. License number DAVID E. KAPLAN, MO D0055583 (10 dober 16, 2000

State Registrar

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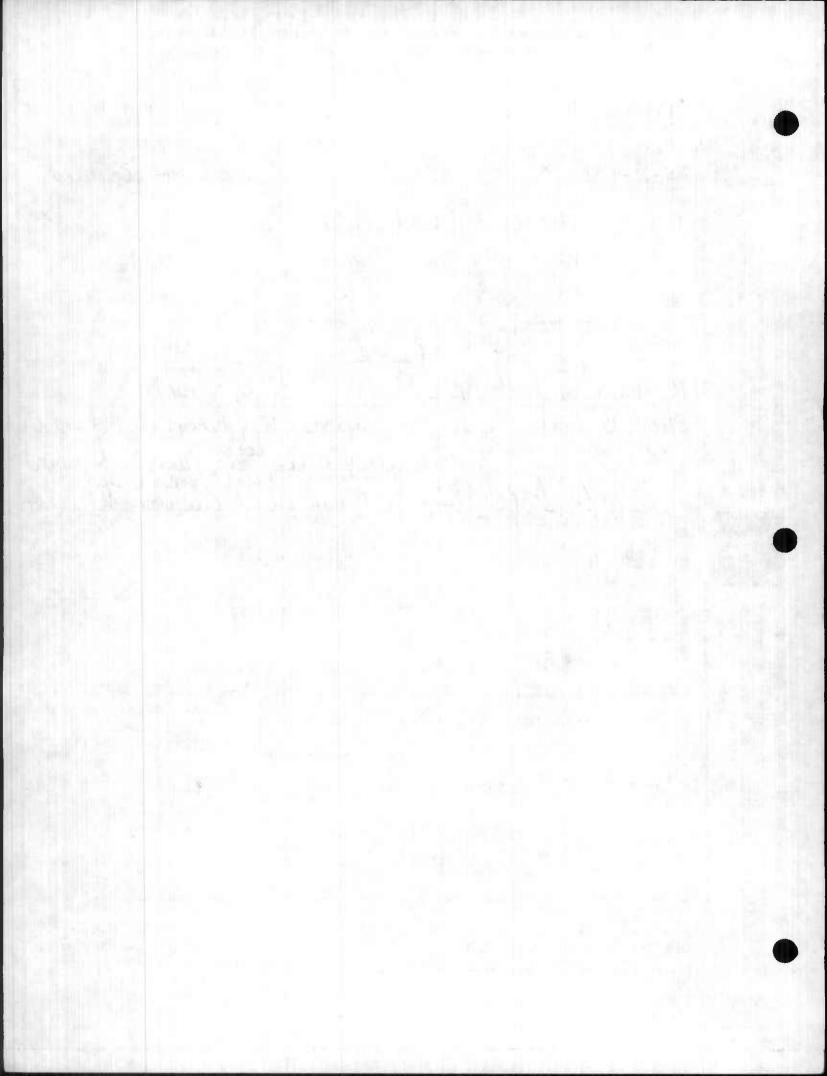
31. Data filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIO E. KARLAN, NO; 6701 N. CHARLES 17,



ROOM 3853, BALTIMONE, MO ZIZOY

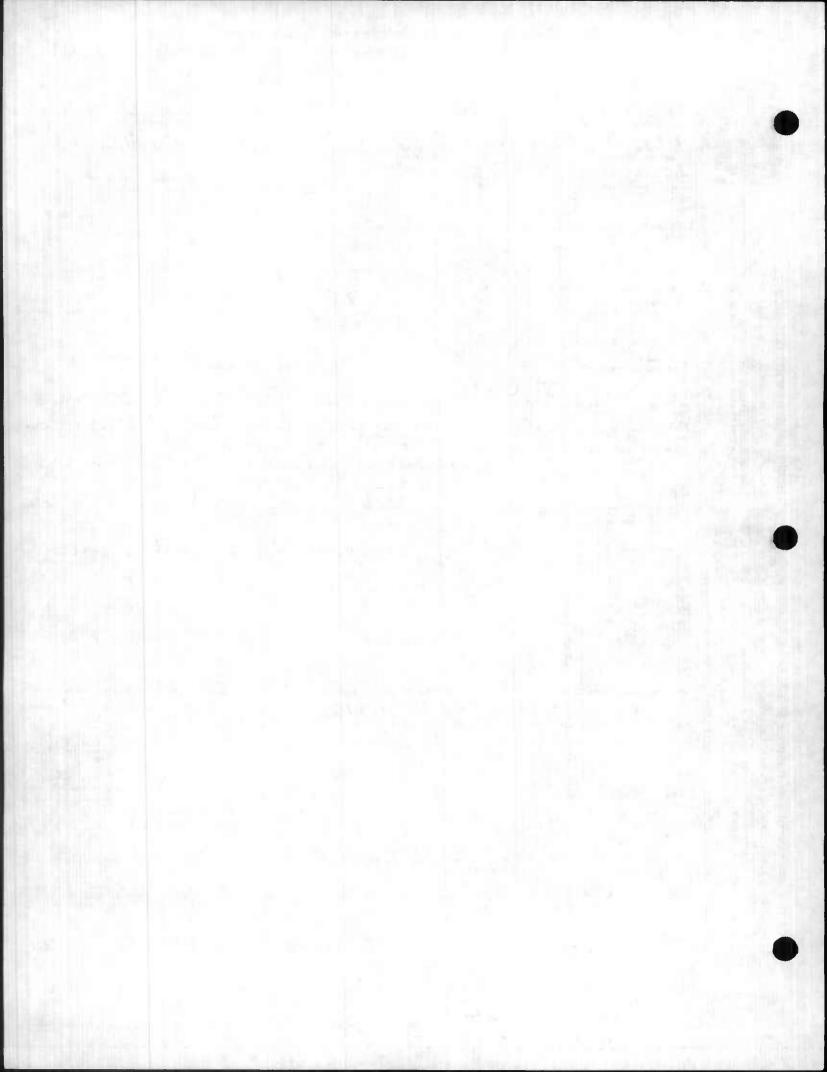


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				State of Marylan		ficate of			Reg. No.	26	201
	Dhi-i-i		1. Decedent's Name (First, Middle, Last,	0 -				2. Date of Dea		Year 3.	Time of Death
	Physici /Medio		William J.	Bayer				Oct 1	3 200	0 6	0:45 AM
7	Examir	er	4a Facility Neme (If not Institution, give	street and number)	Tains	011	4b. City, Town, or Lo	cation of Death	4c. County	of Peath	1 0
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	and		Usual Residence of Decedent  10a. Stete 10b. County	10c. Cit	y, Town or Loca	fion	No.		1	10d. f	Inside City Limits
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Maryland	Men	To	William J	- BAYSR			EV2)	70	CASI	112>	
Mar	2 4 4 4		19a. Informant'a Neme/Relationship (Ty	pe, Print)	19b. Mailing	Address (Street	end Number or Rurs	Route Number	or, City or Town,	State, Zip Cod	10) 21152
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	X		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death ne cause on each line.	h. Do not antar	the mode of dyir	ng, such as cardiac o	or respiretory ar	rest,	fnte	proximete erval Between set and Death
맆	Physician /Medical		Immediete Cause (Final	ACUTE	RAC	TERI	AZ PN	EUMO	NIA	1/4	UEEIC
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Division	or Attending effer death. Director: After i in by the fune	fical	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he				28f. Location (S	Street end Numbe	er or Rurel Ro	oute Number,
ă	교육	Certification:	4 Homicide	building, etc. (Specify	γ)			City or Tov	vn, Stete)		
	To the Hospital or Attend permit is hours effer death to the Funerel Director: completely filled in by the	edical	29e. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) 1 Medical Examination (Check only one)	iclan: To the best of my knower: On the basis of examiner and manner steted.	wledga, death or tion and/or inves	ccurred et the tire stigation, in my o	ne, date and plece, pinlon, daeth occurr	and due to the red et the time,	cause(s) end ma date and placa, a	nner es stated and due to the	i. cause(a)
	Tothe	M	29b. Signafure and title of cartifier			29c. Licans			29d. Date signed		
	Thu,		> 50 human				0641		301019	CK 1	3 2000
	0 /		30. Name and address of person who co	mpleted cause of death (Item	1 23a) (Type, Pri	L PD	Scrite 10	39 8	SOV 1	6	
	Sta	te	31. Dete filed (Month, Day, Year)	32. Registrar's Signa		a rece of	Jun 1		Jer, 1		
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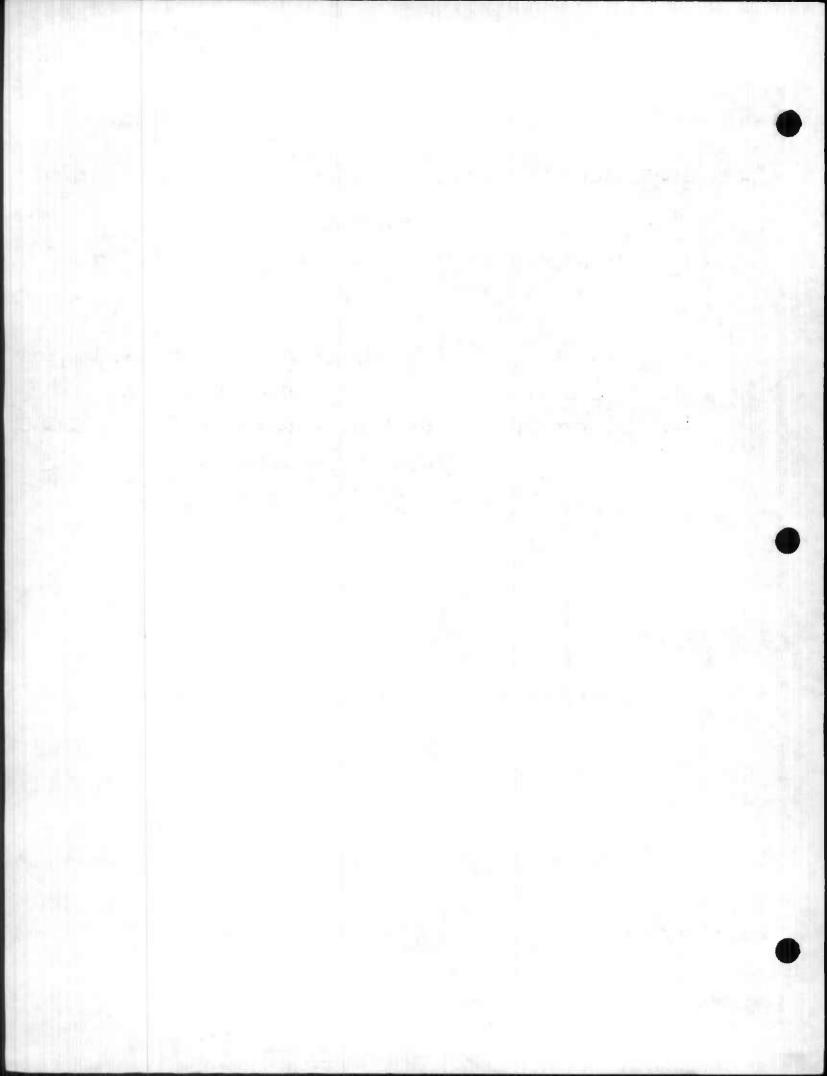


State of Maryland / Department of Health and Mental Hygiene 00 32902

amend item 23a,27 per me G789 11/27/00	11/27/00 yi
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Certificate of Death

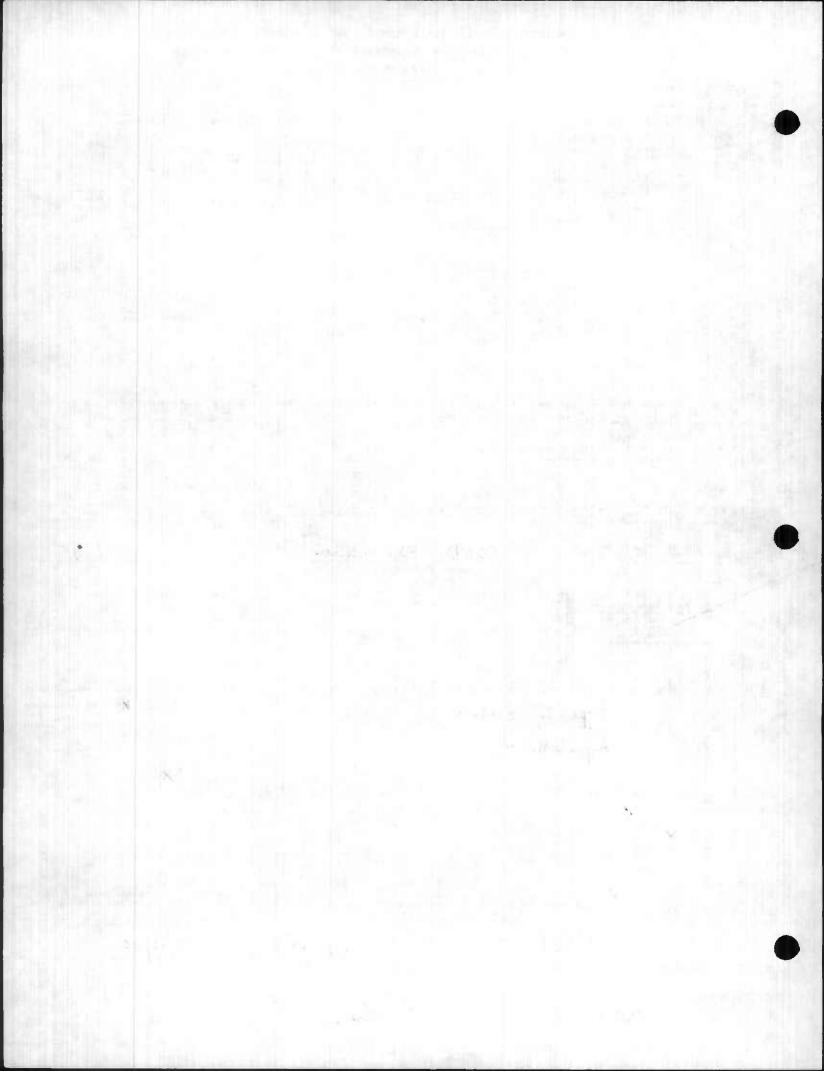
andid 100	Louis per me oros II/I	,00 12	Ocitinos	ALC OF	Dealli		leg. No.		
	1. Decedent's Neme (First, Middla, Last	)				2. Dete of Des	th		3. Time of Death
Physicia		II D				Month	Day	Year	
/Medic	1000	hald Dr	-OWN			OCTOBE	R 10, 2	000	1638 PM
	to Engility Name (If not inctitution aire	street and number)			4b. City, Town, or L	ocation of Deeth	4c. County	of Death	
Examin	BON SECOURS HOSE	זאיידת			DATEMANT	OTM31			
-4	DON SECOURS HOSE	ZIIAL			BALTIMO				
Funeral	5. Social Security Number 6. Sec			dar 1 Year	If Undar 24 Hrs. Hours Min.	8. Date of Birtl (Month, Da)	Voerl	9. Birthp	place (Stata or Foreign
Director	1112-50-151-1 18	M 20 F	Yrs. Month	s Days	Hours Min.	7-3	1-52	Cour	WY MA
Director	212-58-1561					1 3	004		111.0.
2	Usuel Residence of Decedent	1.0.00						1.	m. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.
death with the Maryland one 23a or 28a-f ahow crites to notified at	10a. Steta 10b. County	10c. Cit	y, Town or Location					1	0d. Inside City Limits
Ag ag	5 111	R	a Lina	200					1 De Yes 2 □ No
4 7 9	5 1.10		WITHIN	216					
± 65	10e. Street and Number		10f.	Zip Code			log. Citizen of \	What Cour	ntry?
* * *	2 10 12 11 100	21.100d S		210	1110		//	5	Δ
£ 53	6 1913 M. FOIT	9 00000	1.	2010	(14)			1101	
	11. Marital Status	<ol> <li>Was Decedent Ever in U. Armed Forces?</li> </ol>	S. 13. Was De	cedent of h	Hispanic Origin? (Sp an, Mexican, Puerto	Decity Yas or No-	14. Had	a - Americ ck, Whita,	ean Indian,
11215-0020 within 72 hours after death with the Manylan ene. than "natural", or frams 23a or 28a-1 ahow he Medical Examiner must be notified at	10e. Street and Number 1913 H. Lon 11. Marital Status 1 Never Merried 2 Married	1 ☐ Yes 2 No				, , , , , , , ,	Dia	7	. 1/
21215-0020 d within 72 hours af plene. r than "netural", or the Wederil Exam	3 ☐ Widowed 4 ☐ Divorced	If Yas, Giva	1 Vas	2 No	Specify:		Specify	BI	ACK
		Year or Dates:						-	
2 2 2	15. Decedent's Edu (Specify only highest grad	cation	16a. Decedent's U	sual Occup	pation duning most of world)		16b. Kind of B	usiness/In	dustry
7 4 6	(Specify only highast grad		life. DO NOT	use retire	d) d)	(ing	100		
<b>公</b> 电	Elementary/Secondary (0-12)	College (1-4or 5+)			1		Rais	11	10110-
d 2 Hygie thert	o att		CON 5	ruc	7101		DITIO	J.K.	ruyer
other then	17. Fathar's Name (First, Middla, Last)				18. Mother's Nem	ne (First, Middle,	Maiden Suman	ne)	
od all by	Tab - Bank				100	in in	Barris		
arylar should by nd Menta merked umetic ev	e John Brow	n			HON	nie	Darr	162	
S S S S S S S S S S S S S S S S S S S	19a. informant's Name/Relationship (T)	rpe, Print)	19b. Mailing Addre	ess (Street	and Number or Ru	ral Route Number	r, City or Town,	State, Zip	Code)
Nore, Maryland 212: ges 1 and 2 should be filed within to of Health and Mental Hyglene. If Item 27 is marked other than or other traumatic evant, the Me	Il Union Domi	.1.0	2813	1100	calk 1	Jue. P	110	m.	1 21215
of Health Item 27 other tr	FYTTICE PIO	Wh		NOI	FOIL A	1	DUIT.	111	1 0/10/12
of H	20e. Method of Disposition		Plece of Disposition (I	vame or or other pla	ce)	Date	20c. Location	City or To	own, State
Baltimore, semit. Pages 1 at Department of Hee mportant: If Item: any Injury or othe	1 MBurial 2 Cremetion 3 F	lemoval from State	mahal	1		10 17 0	n D	110	LM
Baltim Semit. Pa Departmen Important: Inty Injury.	4 Donetion 5 Other (Specify)		Davel	1	narden	10-17-01	2 5	ULIT	- 1110
Balti permit. Departm Importa	21. Signature of Funeral Services Licens	00 11 /	22 Name	end Addre	ess of Facility	- ('h	avis Fi	Merc	u Home
Ba Depa Impo any l	b / / . //	10/1. 4/1	mes	7116	yCraw	2, 7.			
	MINIAN	MANTE	200	7 1	=astern	He.	2122	5	
	23a. Part1. Enter the dise to complete shock, or heart faiture.	ications thef causad 🎢 daat	h. Do not enter the m	ode of dyi	ng, such as cardiac	or respiratory ar	rest,		Approximata
45	snock, or heart faiture only of	ne ceuse on each inter						1	Intervet Between Onset and Death
Physician		/						1	
/ /Medical	Immediate Causa (Finel disaese or condition	ARTERIOSCLERO	TC CARDTOVAS	SCIII.AR	DISEASE			1	
Examiner	resulting in deeth)	a	TO GEOTOVIA		2102.02				
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and	Sequentially list conditions,	Dua to (c	or as a consequenca	or):				-	
0 6 8 8	ceuse. Enter Underlying								
2 d io d	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	C Due to /o	r es a consequenca o	6).				-	
X 68760, certificate be executed iding physician and ise as the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	D00 to (0	r es a consequenca c	,,,.					
certific	8							1	
	2	d							
the death by the attar	Part II. Other significant conditions con							i	
cords, P.O. B requires that the death been signed by the atte should be detached for	Part ii. Other significant conditions con	ntributing to death but not res	ulting in the underlyin	g cause gi	ven in Pert I.	23b. Did 1	obacco uss co	ntributs t	o the cause of death?
P.O.	È					10	Yes 2 No	3□ Pro	bably 4 Unknown
	2.								
Records,	Completed by							7	
D in Supplemental							an autopsy		ere autopsy findings vailable prior fo
0 5 9 8	ō					perio	rmed?	CC	ompletion of cause
law law	۵					1		of	death?
The page	5					100	ras 2 No	1	Yes 2 No
						/5			7
the state of	25. Was case referred to medicat examiner?				26. Place of Dea	ith (Check only c	ne)		
of Vital Rec Physician: The law this certificate has b	1 Nas 2 No	lospital:	ER/Outpatient 3D	DOA Ot	har: 4 Nursing H	lome 5 Resid	denca 6 ∏Oti	er (Speci	(h/)
0 th 1 1 1		28e. Date of Injury	28b. Time of				now injury occu		77
E 5 5 5	O 1 ⊠ Naturei 5 ☐ Pending	(Month, Day Year)	injury	28c. Inju	ork?	200. Describer	low injury occu	100	
O # 5 4 5	2 Accident investigation		M		Yes 2 No				
Vision Attanding or death. ector: After	3 Suicida 6 Could not be	28e. Place of Injury - At h	ome form street for	tony office		28f Location /	Street and Num	her or Rur	al Route Number,
Division of Vital or Attanding Physician: The after death.  Director: After this certificate in by the funeral director, part of the funeral director, part of the funeral director, part of the funeral director.	4 ☐ Homicide determined	building, etc. (Specif	y)	tory, ornice		City or Tov		00 01 7101	ar riodio rvamber,
D para	27. Manner of Death  1 Si Naturel  2 Accident  3 Suicida  4 Homicide  2 Homicide  5 Pending investigation  6 Could not be determined								
A STATE		elelen: To the heet of my kno	wledge death occurr	ad at the ti	ime date and place	and due to the	causa(s) and m	annar as i	stated
Division of the Hospital or Attending Physiling & hours after death.  Total Funeral Director: After the completely filled in by the funeral	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina	tion and/or investigat	ion, in my	opinion, death occu	rred at the time,	date and place,	and due t	to the ceuse(s)
2 = 2	one) X	and menner stated.							
0 E N 8 /	29b. Signature and title of certifier		41	29c. Licen	se number		29d. Date signe	d (Month,	Day, Year)
- sHo	6 /) / 101.	Char	- 1 - 1 - 1	O	CME		CITODITI	11	2000
	Carrie	GVV		O.	تلل ب		OCTOBE	11,	2000
/ N	30. Name and address of person who co	moleted cause of death (float	n 23a) (Tune Drint)				-		
V	12111111111111111111111111111111111111	- 40 0		-					
	12. LAKON LOCK	E WAD	111 Penn	Stre	et, Balti	more, Ma	aryland	2120	1
					1		_		
Sta	31. Data filed (Month, Day, Year)	32. Registrar's Signa	sture 19	An.	uks				



State of Maryland / Department of Health and Mental Hygiene 00 32903

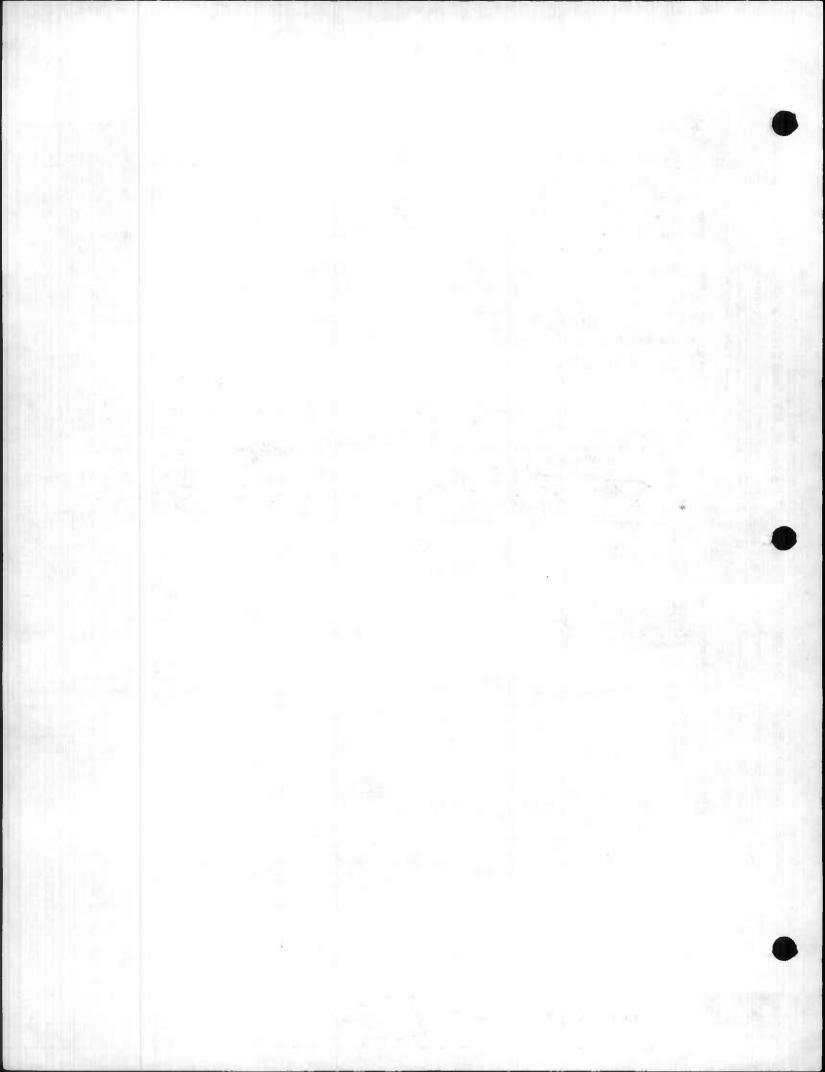
/Medical Examiner	ileen Brown institution, giva strettlestown Interpretation of the street	et and number)	yrs. last birthday)		4b. City, Town, or Lo	2. Date of Deal Month October			3. Time of Death					
Medical   Examiner   4a Facility Name (If no 3676 Lit   5. Social Security Num 210-07-92   Usual Residence of De 10a. State   MD   10a. Street and Number 3676 Lit   4	t institution, give strettlestown I ber 6. Sax 57  becedent  be. County	Pike 7. Aga (In			4b. City, Town, or Lo	October	200	Year	0 45					
### 3676 Lit   5. Social Security Num   210-07-92   Usual Residence of De   10a. State   MD   10a. Street and Number   3676 Lit   3676 Lit   10a. Street and Number   3676 Lit   10a. Street and Number   3676 Lit   10a. Street and Number   3676 Lit   10a. Street   3676 Lit   3676 Lit	tlestown I	Pike 7. Aga (In			40. City, Town, or Lt	ontion of Dooth	_	000	8:45 pm					
5. Social Security Num 210-07-92 Usual Residence of De 10a. State MD  10a. Street and Numbe 3676, T. i. +	ber 6. Sax 57 1 M seedent 0b. County	7. Aga (In					4c. County of	roll						
210-07-92 Usual Residence of De 10a. State MD  10a. Street and Number 36.76. Lit	1 M ecedent 0b. County	21X E		If Under 1 Year	Westminst	8. Date of Birth			on /Chain or Earn					
MD  10a. Street and Number			l Yrs.	Months Days	Hours Min.	Month, Day July 5	Year) 1906	Country	ce (State or Fora y)					
10a. Street and Number	Carro	10	c. City, Town or Lo	ocation	April 1	- 4777		100	d. Inside City Lim					
10a. Street and Number 3676 Lit	Callo.	11	Westmins	ter					1 ☐ Yes XX					
3676 Lit	ər	THE ST		10f. Zip Code		1	0g. Citizen of W	/hat Countr	y?					
	tlestown I	Pike		2	1158-2029		USA							
11. Marital Status	12.	Was Decedent Ever	in U,S. 13.	Was Decedent of I	Hispanic Orlgin? (Spean, Mexican, Puarto	ecify Yes or No-		- America						
3X) Widowed 4 C		Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas:		1 Yes, specify Cub 1 ☐ Yes 2 Ž No		Hicen, atc.)	Specify:	k, White, et	White					
	only highast grada or		16a. Dece	dent's Usuel Occup	pation during most of work	ina	16b. Kind of Bus	siness/Indu	istry					
Elementary/Seconda		College (1-4or 5+)	life.	DO NOT use retire	d)	"'9								
12			Hoste	ess			Restau	rant						
17. Falher's Name (Fir					18. Mother's Name			9)						
Daniel Eu	gene Lally	Y			Mary Go	ldena Be	elknap							
19a. Informant's Name			19b. Maili	ng Address (Stree	t end Number or Run	al Route Number	r, City or Town,	State, Zip C	Code)					
Nancy J.	Mack (Dau	ighter)	3676	Littles	town Pike	Westmi	nster,	MD 21	158-2029					
20a Method of Dispos			Ob. Place of Dispo	osition (Neme of matory or other ple	nce)	Date 10/16	20c. Location - 0	City or Tow	m, State					
Maurial 2 □C 4 □ Donation 5 [	Premation 3 □Rem □ Other (Specify)	oval from State			Gardens		Davidso	nvill	Le, MD					
21. Signature of Funer	ral Service Licensee	0	2	2. Name and Addre		,								
ESEES	00	< //	1. 0		y Funeral									
23a Part Enter the	Muly	ions that caused the	death Do not en	12 Ridge	ely Avenue	Annap	olis, M		O1 Approximata					
23a. Part I. Enter tha c shock, or heart for	eilure. List only only	cause on each line.	death. Do not on	ter the mode or dy	ng, such as cardiac	or respiratory arr	031,		Interval Between Onset and Death					
Physician Immediate Cause (Fin	nel .	0-0	0.	1+										
Examiner disease or condition resulting in death)	8	COP	D Ex	acusati	0-				7'					
5		Due	to (or as a conse	quence of):				- 11						
	b													
Sequentially list condition of the condi	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c													
Cause (Disease or injuint that initiated events	ury c							i						
Cause (Disease or injuthal initiated events resulting in death) Las	t	Due	to (or as a consec	quence of):										
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The clear to the death control of the cite				indarlying ceuse gi	ven in Part I.				the cause of dea					
y Ph	type II	- diaset	i-,			1 U Y	os 2 No	3 Probe	ably 4 Unkn					
8 66 8	. 11	ivi.				24a. Was a	n autones	24h Wer	e autopsy finding					
The law requirements been spage 2 should	Lyputers	10-				perfor		avai	ilable prior to					
mpies p	1		45-11						eath?					
C Om						1□Y	as 2 No	10	Yes 2□ No					
25. Was cese referred examiner?	I to medicel				26. Place of Deat	h (Check only or	ne)							
O O O	Hos	pilal: 1 Inpatient	2 ER/Outpatie	nt 3 DOA	her: 4 Nursing Ho	me 5 Resid	ence 6 Othe	er (Specify)						
E so to la la Yes 2 No		28a. Dete of Injury (Month, Dey Ye	ar) 28b. Time o	ef 28c. Inju	ry at ork?	28d. Describe h	ow injury occurre	ed						
E 5 1 1 103 2 20 100	E Dending		, ,,,,,,		Yes 2□No									
E 5 1 1 103 2 20 100	Investigation		At home farm st	reel, factory, office				er or Rural	Route Number,					
E 5 1 1 103 2 20 100	Investigation	28e. Place of Injury -	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, Stete)											
27. Manner of Death 1 Constitution of the cons	Investigation 6 Could not be	28e. Place of Injury - building, etc. (S	pecify)											
27. Manner of Death 1 Manuer o	Investigation  Could not be determined  Certifying Physician	building, etc. (S	pecify) y knowledge, deat											
27. Manner of Death 1 Constitution of the party of the pa	Investigation  Could not be determined  Certifying Physician	building, etc. (S	pecify) y knowledge, deat											
27. Manner of Death  1 Manual  28. Manner of Death  1 Manual  29. Manner of Death  1 Manual  20. Manual  20. Manner of Death  1 Manual  20. Manner of Death  20. Manner of Death  20. Manner  20. Manner of Death  20. Manner  2	Investigation  Could not be determined  Certifying Physical Medical Examiner	building, etc. (S an: To the best of m : On the basis of exa	pecify) y knowledge, deat	vestigation, in my 29c. Licen	opinion, death occur sa number	red at the time, o		and due to	the cause(s)					
27. Manner of Death  1 Manuer of	Investigation  Could not be determined  Certifying Physical Medical Examiner	building, etc. (S an: To the best of m : On the basis of exa	pecify) y knowledge, deat	vestigation, in my 29c. Licen	opinion, death occur sa number	red at the time, o	date and place, a	and due to	the cause(s)					
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**ORIGINAL** 



State of Maryland / Department of Health and Mental Hygiene 00 32904

		, , , , , , , , , , , , , , , , , , , ,	Certifica	ate of	Death	F	leg. No.	52	304	
Physician /Medical	1. Decedent's Name (First, Middle, Las ABRAMS SA	MAN BERTI	нА			2. Dete of Dea Month 1 C	th D48/00	Year 3.	Time of Death 9:00 PM	
Examiner	42 Facility Name (If not institution give	G HOME		4	b. City, Town, or L KESING	TON	MONTO	SOMERY	COUNTY	
Funeral Director		7. Age (In yrs.	Month	der 1 Year ns Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, De) 9/15/	Year)	9. Birthplace Country)	(State or Foreign RUSSIA	
with the Maryland a or 28e4 show Libe notified at	I Usual Residence of Decedent  10a. State I 10b. County M D N T G O M		y, Town or Location KESINGT						Inside City Limits	
23a or 28a-/ show ust be notified at ral Director	3227 BEL.PRE.	ROAD	10f.	Zip Code 2 (	0906	10g. Citizen of What Country?				
Examiner in by Funer	11. Marital Status  1 Never Married 2 Married  3 XI Widowed 4 Divorced	12. Wes Decedent Ever in U. Armed Forces?  1 Yes 2\ No If Yes, Give Year or Dates:		W	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - American li ck, White, etc. :: WHI		
yglene, ser than "naturn rt, the Medical.] Completed		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 1 2 t n  16a. Decedent's Usual Occupation (Give kind of work done during kind		during most of work		16b. Kind of Bu	16b. Kind of Business/Industry			
arked othersic arise event. To Be C	17. Father's Name (First, Middle, Last)  JACOB SAIDMA	N			18. Mother's Nem	e (First, Middle, RL STE]		10)		
27 is mer traum	19a. Informant's Name/Relationship (7 CAROLE KOLKER (D		19b. Meiling Addr 5814 LI	NDEN	SQAURE	Route Number	r, City or Town,	State, Zip Coo	20852	
ant: If Itam ury or othe	20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removel from State	Place of Disposition (formetery, crematory of ORGETOWN	or other pled		Date 10-9-00	20c. Location - WASHII	-		
any inj	21. Signature of Funeral Service Licenter	The I			ss of Fecility Au Street U		_1		Al Home	
sician edical miner	23a. Part. Enter the disease, of companies, or hear failure. List only of immediate Cause (Finel disease or condition resulting in death)	a. ASPIR	ATIONO or as e consequence	F	NEUM			On	eval Between set end Deeth	
outel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
has been signed by the estending physician and ge? 2 should be detached for use as the buriel-transit mpleted by Physician/Medical Examir	resulting in death) Last	Due to (o	r es e consequence d	of):						
by the ettending stacked for use Physician/M	Part It. Other significant conditions co	g cause giv	en in Part I.		**		cause of death?			
by Pt	HLZHEIME	iris Dem	ENTIA						y 4 Unknown	
page 2 should be Completed by							med?	availat comple of deal	ole prior to ation of ceuse th?	
certificate ha	25. Was case referred to medical				26. Place of Deel	1 ☐ Y		1 🗆 Ye	s 2D(No	
9 0	axaminer? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Oth	er: 4 Nursing H	ome 5 Resid	ience 6 □Oth	ner (Specify)		
To the Fundre Director: After the completely filled in by the funeral Medical Certification:	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  2 Accident 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h building, etc. (Specif	28b. Time of Injury M ome, lerm, street, lac		yat k? Yes 2□No	28f. Location (S City or Ton	Street and Numb		oute Number,	
within 24 hours of To the Funeral Di completely filled in Medical Cer		reician: To the best of my kno liner: On the besis of examina and manner stated.								
To the comple	29b. Signature and title of certifier			29c. Licens			29d. Date signe			
	30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type, Print)	2 Cou	rt #200	Olne	ey, m	> 209	832	
State	31. Date filed (Month, Day, Year)	32. Högistrar's Signa	iture &	P .						



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death John Baranowski Jr. 4c. County of Death 4a Facility Name (If not institution, give street and number) n/a mor If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 12 M 2□ F 217-24-1708 Maryland June Usual Residence of Decedent 10a, Stete 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7494 Rabon Ave. 21222 USA Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Stetus 14. Race - American Indien, Black, White, etc. 1 Never Merried 2 Merried 1- Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Toe Motor Operator Strohs Inc. 8th 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) John F Baranowski Sr. MArgaret Pozniak 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Baranowski / wife 7494 Rabon Ave. Baltimore Md. 21222 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory Inc. 10/16/2000 Baltimore MD 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 300 MAce AVe. Baltimore MD 21221 Approximete Intervel Between Onset end Deeth 23e. Pert1. Enter the disease, or comblications that caused the deat shock, or heart failure. List only one cause on each line. To not enter the mode of dying, such as cardiac or respiratory errest, Immediate Ceuse (Final disease or condition resulting in deeth) Due to (or es e consequence of): Due to (or es e consequence of): Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated as or injury thet initiated events resulting in deeth) Lest Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings eveilable prior to completion of ceuse of death? 24a. Wes en eutopsy performed? 2 No 1 ☐ Yes 2 ☑ No 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Mennier of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work?

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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**Funeral** 

Director

Items 23s

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Box 68760. 8 200 P.O. 4 Records, page 2 certificate Division of Vital 2 After death. after death Director:

Examiner

Physician/Medical p Completed Be Certification: To

1 Neturel

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signeture end title of certifier

State Registrar

Medical

1 8 2000

5 Pending

6 Could not be determined

investigetion

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29c. License number

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the cause(s) end menner steted. 29d. Dete signed (Month, Day, Year)

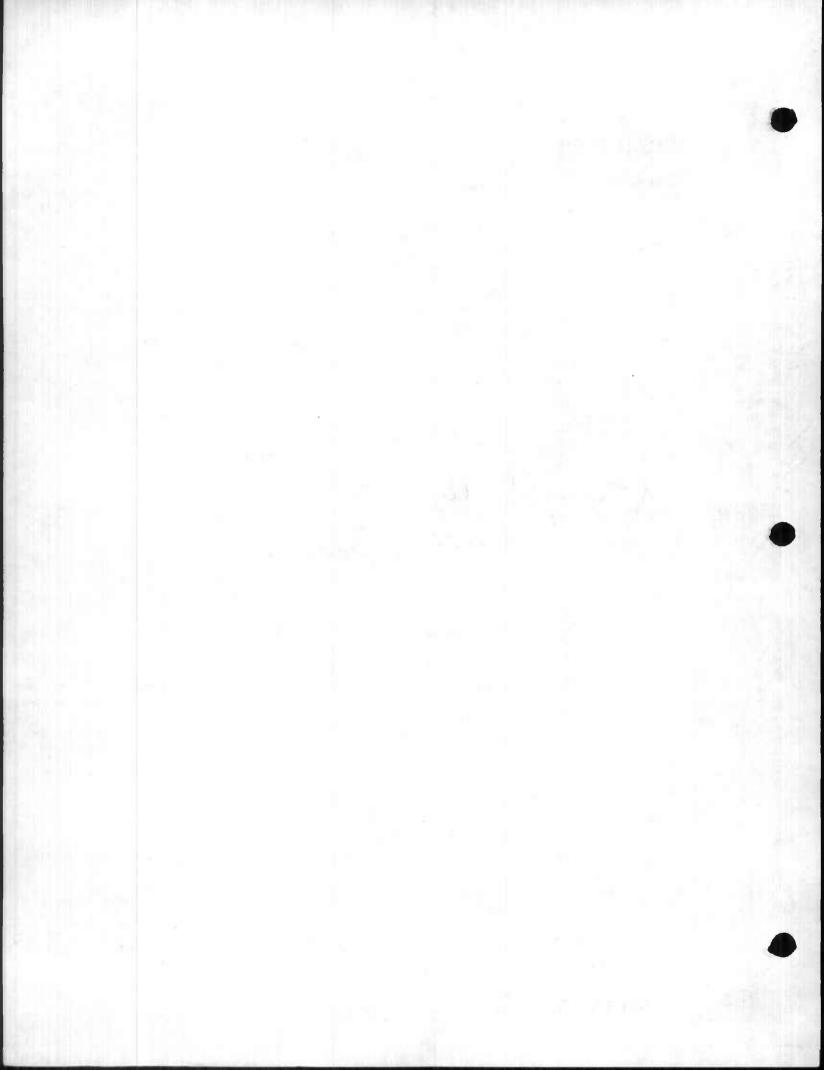
📳 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner es stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

pleted cause of death (Item 23a) (Type, Print)

32. Registrer's Signature

To the Hospital or within 24 hours at to the Funeral D



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death (3 Dey **Physician** OCT 2000 Virginia M. Bertrand /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c County of Deeth Examiner Eastpoint Nursing Home Dunda1k Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 21 F Months Deys Hours Min. Yrs. Director 214-42-1983 June 13, 1943 Usual Residence of Decedent 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? filed within 72 hours efter death with 122 Bouldin St. 21224 USA Funeral 11 Marital Statue 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. Yes 27 No 1 Never Married 2 Married 1 Yes 2 No Specify: Completed by 3 Widowed 4 Divorced Year or Dates White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry th and Mental Hygiane.
7 is marked other than traumatic event, the Me Elementery/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own Home Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Peges 1 end 2 should be nent of Haalth and Mental John Edward Noz Ellen White 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) nt of Haalth a If Item 27 is or other trai Ellen Palugi Daughter 209 S. Eaton St. Baltimore, MD 21224 20b. Plece of Disposition (Name of cametery, crematory or other plece) 20a Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Pege Depertment of Important: If any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) Garrison Forest Cemetery 10/18 Reisterstown, MD 22. Name end Address of Fecility Moran Ashton Dabrowski Funeral Home, Inc. Baltimore, MD 21224 3000 East Baltimore ST 23e. Peri 1. Enter the distance, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or hear failure. List only one cause on each line. **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical 4/25 DEMINTIA Examiner Due to (or es e consequence of):
MUL7 - / NFARG YRS Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest bunel-tran Physician/Medical Due to (or es e consequence of): usa as the Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed' certificate has page 2 1 ☐ Yes 2 No 1 Yes 2 □ No Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Deeth Dete of Injury (Month, Dev Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred After 5 Pending Investigation 1 Naturel 1 Tes 2 No 2 Accident Director 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) B 4 T Homlcide 8 the Funeral terifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end manner stated. 29e. Certifier (Check only 29b. Signeture end title of cartifier 29d. Date signed (Month, Day, Year) 29c. License number To Willelie Masslew DUTOBER 16, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATTHEW MCNATAGY SSOS (APRICIAL) BAYVEN CIRCLE BAK 21224 OCT 1 8 2000 32. Registrer's Signeture

**DHMH 16 Rev 6/95** 

State Registrar

21215-0020

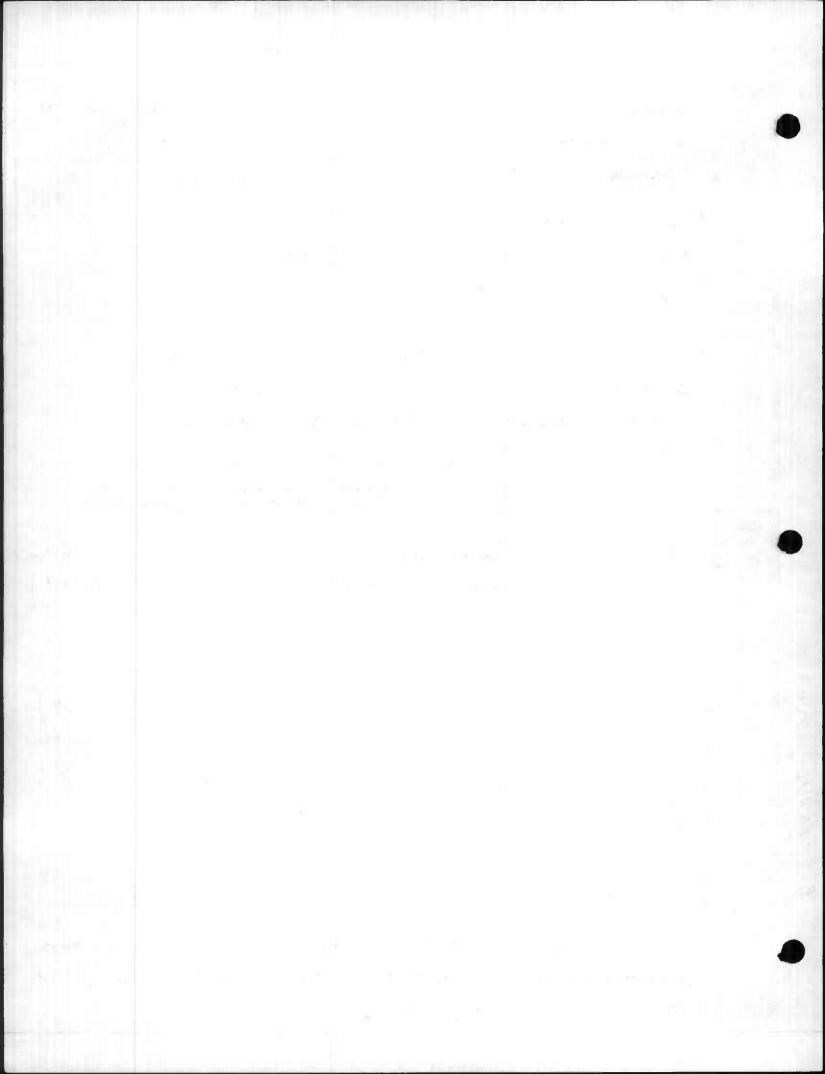
P.O. Box 68760.

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Yaar **Physician JOHN JOSEPH** CONNOR, October 15 2000 6:10am /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Baltimore If Undar 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Dec. 27, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthdey) **Funeral** Months Days Hours 1⊠M 2□F Yrs 88 218-01-5087 1911 Director Maryland Dec. Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 ☐ Yas 2 No Directo Maryland Baltimore Towson 288-4 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 104 Maryland Avenue 21286 U.S.A. Harrie 23a Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Giva <sup>2</sup>A Yaar or Datas: 13. Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - Amarican Indian, Black, Whita, etc. the Medical Examiner 72 hours after 1 Never Married 2 Married 21215-0020 8 1 ☐ Yas 2 ☑ No Specify. þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry tiled within Elementary/Secondery (0-12) Coltega (1-4or 5+) 1 year Business Analyst Manufacturing Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) ed pinous nd Mental merked of Joseph Patrick Connor Anna McNicholas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If then 27 is in any injury or other traun once. Marjorie Connor 104 Maryland Avenue Towson, Maryland 21286 (wife) Baltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other piece) 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1 ABuriet 2 Cremation 3 Removal from Stata 4 □ Donation 5 □ Other (Specify) Dulaney Valley Memorial Gardens 10-18-00 Timonium, Maryland 21. Signature of Funaral Sarvice Licenses 22. Nama and Addrass of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 herran 23a. Part1. Enter the disease, of complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Deeth **Physician** longestive Heart-Failure Immedieta Causa (Final diseasa or condition resulting in death) /Medical **Examiner** Physician/Medical Examiner certificate be executed Sequantially list conditions, if any, laading to immadieta cause. Enter Underfying Cause (Disease or Injury that initiated events rasulting in death) Last use as the burial-fran Dua to (or as a consequence of): 68760 attending physicien Dua to (or as a consequence of): Box Pert II. Other afgnificant conditions contributing to death but not rasulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been signed by Arter Dijease λq 24b. Ware autopsy findings page 2 should Medicai Certification: To Be Completed 24a. Wes an eutopsy evailable prior to completion of cause of death? 1 Yas 2 No 1 □ Yes 2 □ No of Vital after deeth.

Director: After this certifical of In by the funeral director, 25. Was casa rafarred to medicat 26. Placa of Death (Chack only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Data of Injury (Month, Day Year) 27, Mannar of Death 28c. Injury at Work? 28d. Describe how injury occurred Attending Division XXNaturat 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datamined 3 Suicide 28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homicida 6 within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Cartifier completely and mannar stated. 29b. Signatura and titla of certifiar 29c. License number 29d. Date signed (Month, Dey, Year) D43725 30. Nema and address of person who completed cause of death (Itam 23a) (Type, Print) Tarig Mahmood, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093

DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day, Year)

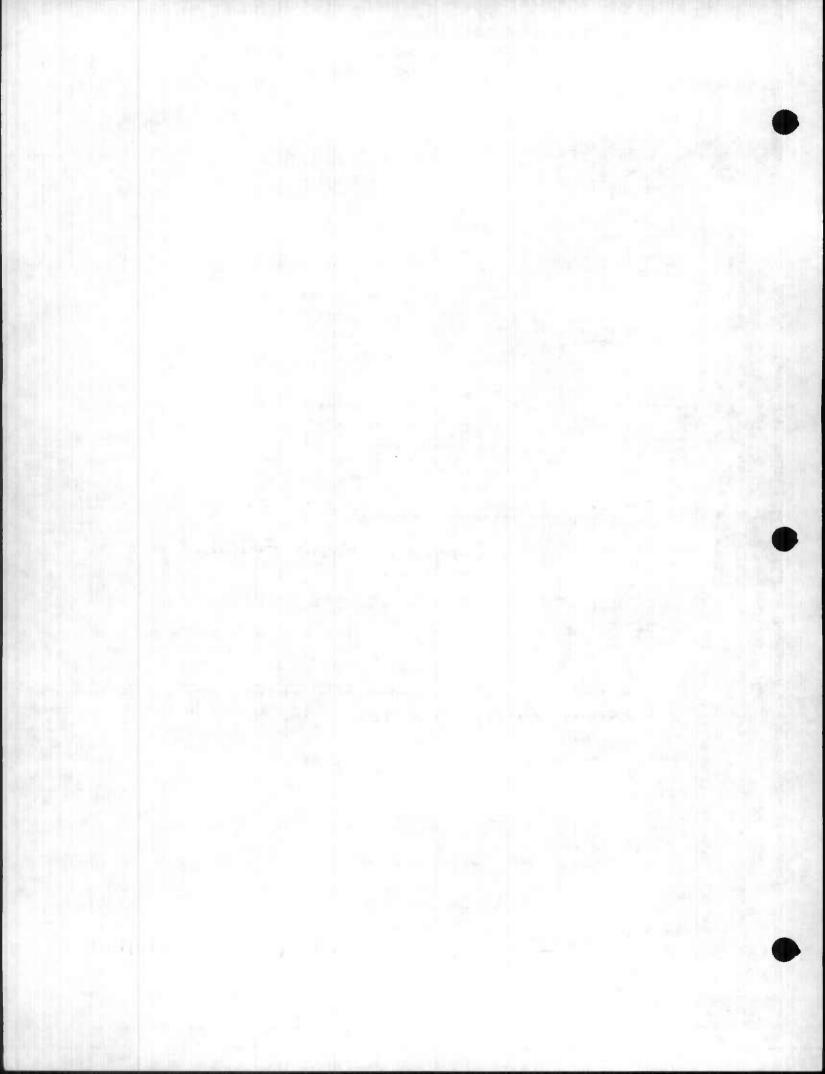
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CONNOR,

ORIGINAL

32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 2000 Day 10 Month **Physician** 2:00PM /Medical 4a Facility Name (If not Institution, give street and number) 6001 MUNCASTER MILL ROAD 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY CASEY HOUSE 7. Age (In vrs. last birthday) 9. Birthplaca (State or Foreign Country) 5. Social Security Number 244 - 58 - 7889 If Undar 24 Hrs. **Funeral** 1 M 2 XF Days Min Months Hours Director Usual Residence of Dacedent 10a. State 100 MONTGOMERY 10c. City. Tawn or Legation RSBURG 10d. Inside City Limits thems 23a or 25a-f show 1 Yes 2 No Director ital Hygiere. Id other than "natural", or them 23e or 28e-1, event, the Medical Examiner must be notifie 10e. Street and Number 18614 SANDPIPER LANE 10g. Citizen of What Country? 10f. Zip Code 20879 Funeral permit. Pages 1 and 2 should be filled within 72 hours after deal. Department of Health and Mental Hygiere. Important if them 27 is merited other in any fellury or other traumers of other pages. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yas, Give Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black. White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Specify: BLACK Specify: þ 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation
(Give kind of work dona during most of working
life. DO NOT usa retired)
UNKNOWN 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th 18. Mother's Name (First Middle Maides Surrame) 17. Father's Name (First, Middle, Last)
JAMES COWAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18614 SANDPIPER LANE GAITHERSBURG MD. Man Informents Nama (Fellarionship Type Nicint) 20b. Placa of Disposition (Name of Cemerals crematory prother planet TARY 10/14/00 WASHINGTON D.C. 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from Stata 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Li 2A Nasagand Noder ROY Schitzer FUNERAL HOME 3821 14th St.N.W. WASHINGTON D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician /Medical Immediate Cause (Final disaase or condition resulting in daath) 2 YRS NON-HODGKIN LYMPHOMA Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the deeth certificate be executed use as the burial-transit Sequentially list conditions, if any, laading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 ☐ Unknown HYPERTENSION Division of Vital Records, Medical Certification: To Be Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of ceuse of death? page 2 : 1 □ Yes 2 No 2 No Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) o the F To the 29c. Licansa number D 0 9 4 7 0 29d. Data signed (Month, Day, Year) 10/10/2000 29b. Signatura and title of certifier of person who completed ceuse of death (Item 23s) (Type, Print)
P. LIBRE M.D. 10400 CONNECTICUT AVENUE KESINGTON MD. 20895

Registrar **DHMH 16 Rev 6/95** 

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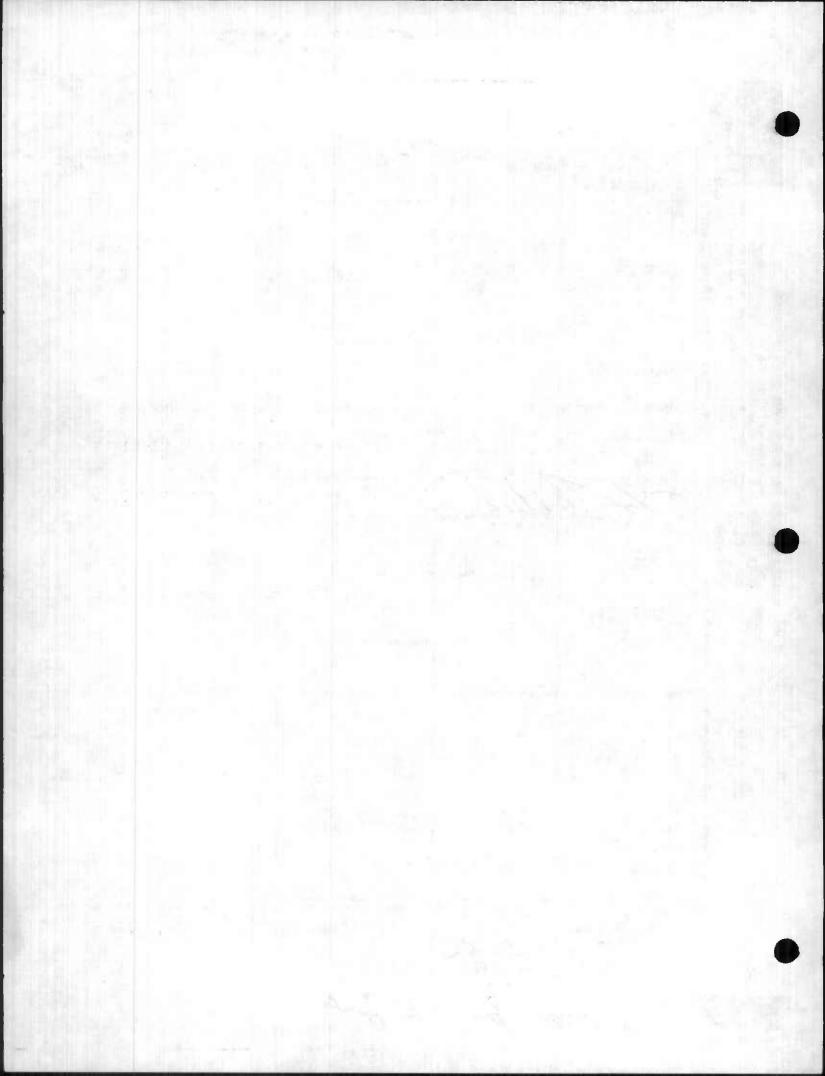
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31. Date filed (Month, Day, Year)

32. Registrar's Signature

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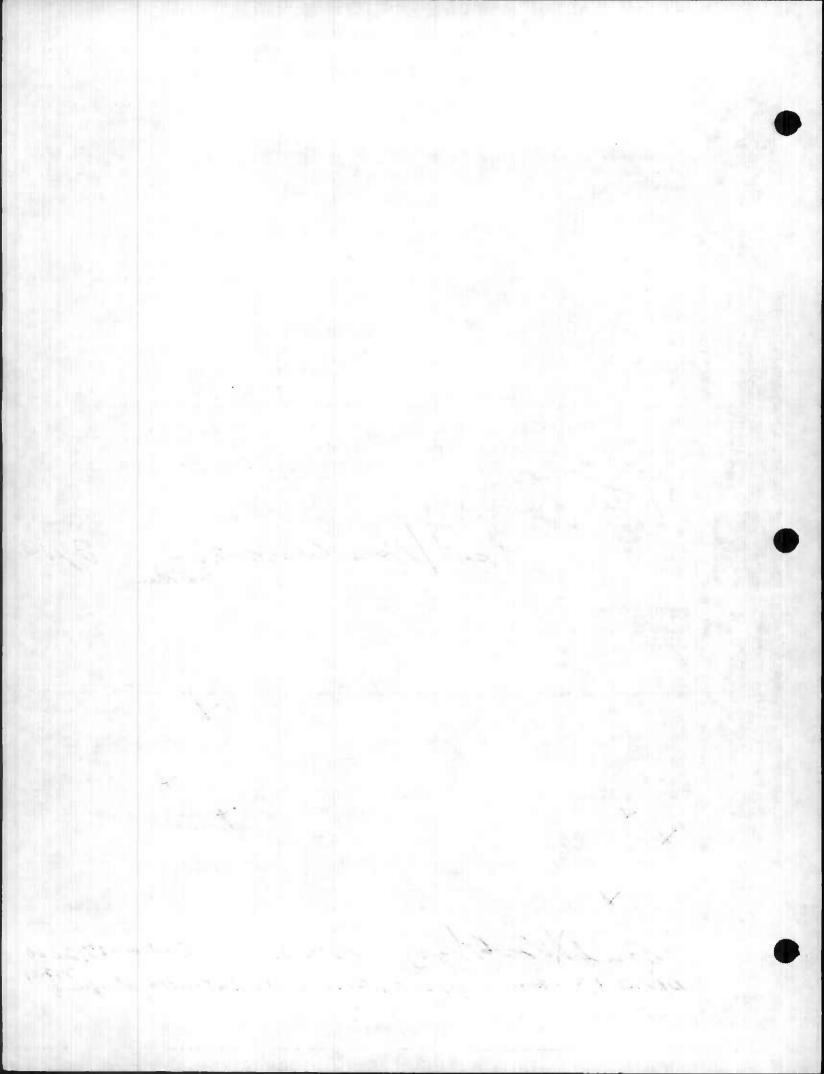


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	Examine		4a Facility Name (	If not institution, giv	va street and numb	er)				4b. City, Tov	vn, or L	ocation of Death	4c. County	of Death										
		п	305 Ni	cholsor	n Road					Ess				ltir	more									
	Funeral Director		5. Social Security N 160–20–4		Sex 7. ▶○XM 2□ F	Age (In yrs.		Months	Days		Min.	8. Date of Birth (Month, Day, Sept. 16	Year) 5 1927	9. Birthp Court PA	place (State o. ntry)	r Foraign								
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21215-0020	urs a	by Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Marr</li><li>3 ☐ Widowed</li></ul>	ried 2 ∑ Married 4 □ Divorced	12. Was Decede Armed Force 1 TYes 2 If Yas, Giva Year or Date	es?	,S.	13. Was Dece It Yes, spe 1 ☐ Yas	cify Cut	oan, Mexican,	gin? (Sp , Puarto	ecify Yas or No- Rican, etc.)		k, White,	ite									
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Va	should be end Mental a marked of aumatic ev	0	John	H Clark							Ada	L Laytor	1											
a	2 sho end is m		19a. Informant's N	ame/Relationship	(Type, Print)		19b. N	Mailing Address	s (Stree	t and Numbe	r or Rui	al Route Number,	City or Town,	State, Zip	Code)									
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ec	hes by ge 2 st	0											1.5		death?	4036								
- H	The late he pege	5										1 □ Ya	s 20 No	1[	Yes 2	No								
ita/	certificate rector, per	U	25. Was case refer axaminer?	rred to medical						26. Place	of Dea	th (Chack only one	a)	T-F										
	0 00	0	1 Yes	No	Hospital: 1 🗆 Inp	atient 2	ER/Outp	atient 3 D	OA O	ther: 4 Nu	rsing Ho	ome 5 Resida	nce 6 Othe	r (Speci	ty)									
101	ding Ph h. After th tuneral		27. Manner of Deat	th 5 Pending	28a. Date of (Month,	Injury Day Year)	28b. Tin Inju	ne of :	28c. Inju	ury at		28d. Describe ho	w injury occurr	ed										
0	Attending or death.	BEI	1 Natural 2 Accident	investigatio	on			M		Yas 2 1	No													
Division	Atte		3 ☐ Suicida 4 ☐ Homicide	6 Could not be determined	200. Place Of	Injury - At h	ome, farm	, street, factor	y, office			28f. Location (Str. City or Town		ar or Aura	al Route Num	iber,								
Ö	ts after death.  al Director: After ted in by the tunera	9	4 D Homicide		building	, etc. (opecin	y)					Ony or roun	, Diato,											
	Fundamental or Fundam	BOICE	29a. Cartifier (Check only one)		hysician: To the be miner: On the basi and manner	s of examina										;)								
			29b. Signature and	title of certifiar	12.	. 1				nse number			d. Date signed											
	1.0		10	LX	Varia	MA		,	Do	245	25		Deta	ber	177	0 40								
	P	1	20 Name and add	THE PARTY OF THE P	completed cause	of death (tr	220	tpo Brieth	-	100	_		<u> </u>		1100	100								
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	000		31. Date filed /Mon			istrar's Signa	ature	UU	. 4.	CRF A		104111	1	,,,	yang	7								
	State Registrar	7	31. Date filed (Mon OCT 1	8 2000	Senet	~ /	9	1																

**ORIGINAL** 



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item24a,25,26 perPHYg788 101/8/2000 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Month Day September 25, 2000 JAMES DUCKETT 11:26 AM 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, giva street and number) 4c. County of Deeth 3000 Towanda Ave #110 Baltimore if Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Aug 26, 1937 If Under 1 Year 5 Sociel Security Number Birthpiece (State or Foreign Country) MD 6. Sex 1₽ M 2□ F 7. Age (In yrs. lest birthday) Months Deys Yrs. 213-34-1099 Usuel Residence of Decedent 10e State 10b. County 10c, City, Town or Location 10d. insida City Limits Baltimore 1X Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Cifizen of Whet Country? 3000 Towanda Avenue #110 21215 IISA 13. Wes Dacedent of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Evar in U.S. 14. Race - Amarican Indian. Armed Forces? 1 Yas 2 No If Yes, Give Yaer or Detes: Bleck, White, etc. 1 ☐ Never Married 2 Married 1 Yes 2K No Specify: Specify: black 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Coilege (1-4or 5+) driver automobile 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Margarite Duckett 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a, informent's Neme/Reletionship (Type, Print) Mary L. Duckett/spouse 3300 N. Hilton Street #2 Baltimore, MD 21216 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) Dete 20c. Location - City or Town, Stete 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 Other (Specify) in state 21. Signature of Funeral Service Licensea Ronald S. Wade, 22. Name end Address of Facility Director State Anatomy Board 655 W. Baltimore Street love Baltimore, MD 21201 23a Part I. Enter the disease, of complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart feilure. List only one ceuse on each line. Approximata Intervel Between Onsat and Daath immediate Ceuse (Final SUDDEN DEATH disease or condition resulting in daath) Due to (or es e consequence of): DIABETES Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death?

**Physician** /Medical \_\_\_aminer

**Physician** 

/Medical

Examiner

MD

**Funeral** 

Director

"natural", or items 23s or 28s-f show edical Examiner must be notified at

Hygiene. other than "nature ent, the Medical I

marked other I

Important: If it sany injury or c

Pages 1 and 2 should be till ment of Health and Mental Hi antt. If Nem 27 is merked oth

72 hours after

filed within

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

Be 2

Examiner

Physiclan/Medical

þ

Completed

Be

2

Certification:

Medical

29a. Certifier

attending physician and for usa es the bunel-transit the s signed by the certificate has blirector, page 2 s al or Attending Physician: T s aftar death. Il Director: After this certificat ed in by the funeral director, p.

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

1 Yes 2 No 3 Probably 4 Unknown

PERIPHERAL VASCULAR DISEASE

24b. Were eutopsy findings eveilable prior to 24e. Was en eutopsy completion of ceuse of deeth?

26. Piece of Death (Check only one)

1 Yes 2 No

1 ☐ Yes 2 ☐ No

25. Was cese referred to medicel examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28b Time of 28d. Describe how injury occurred 28c. injury et Work? 28e. Dete of injury (Month, Day Year) 5 Pending 1 Naturel 2 Accident 1 Yes 2 No investigation 6 Could not be determined 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as steted.

2 Medicat Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, dete end plece, and due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier

DCT

29c. License number D40059 29d. Date signed (Month, Day, Year)

225.6 REEVE ST BACT MS 21201

10/2/00

30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

MD.MAS Donner UNIV. OF MS MESICAL

2000

31. Data filed (Month, Dey, Yeer)

j

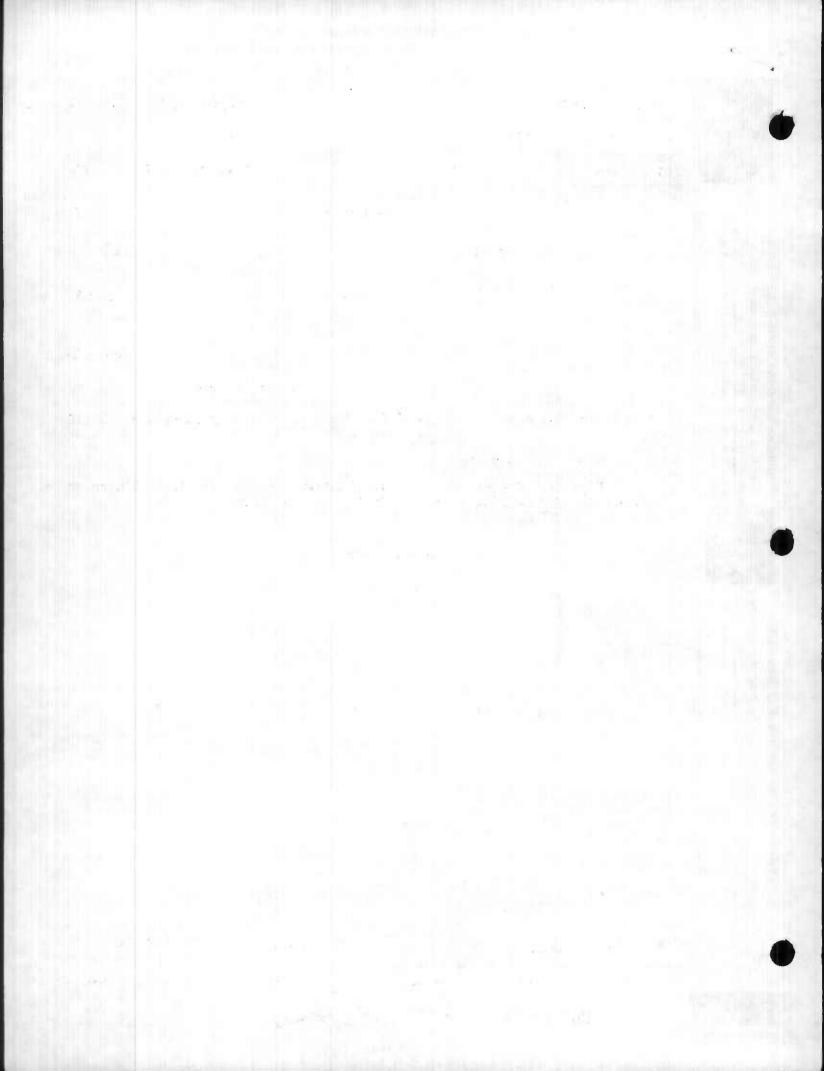
32. Registrar's Signature

CENTER

State Registrar

n 24 hour. the Funeral Directory

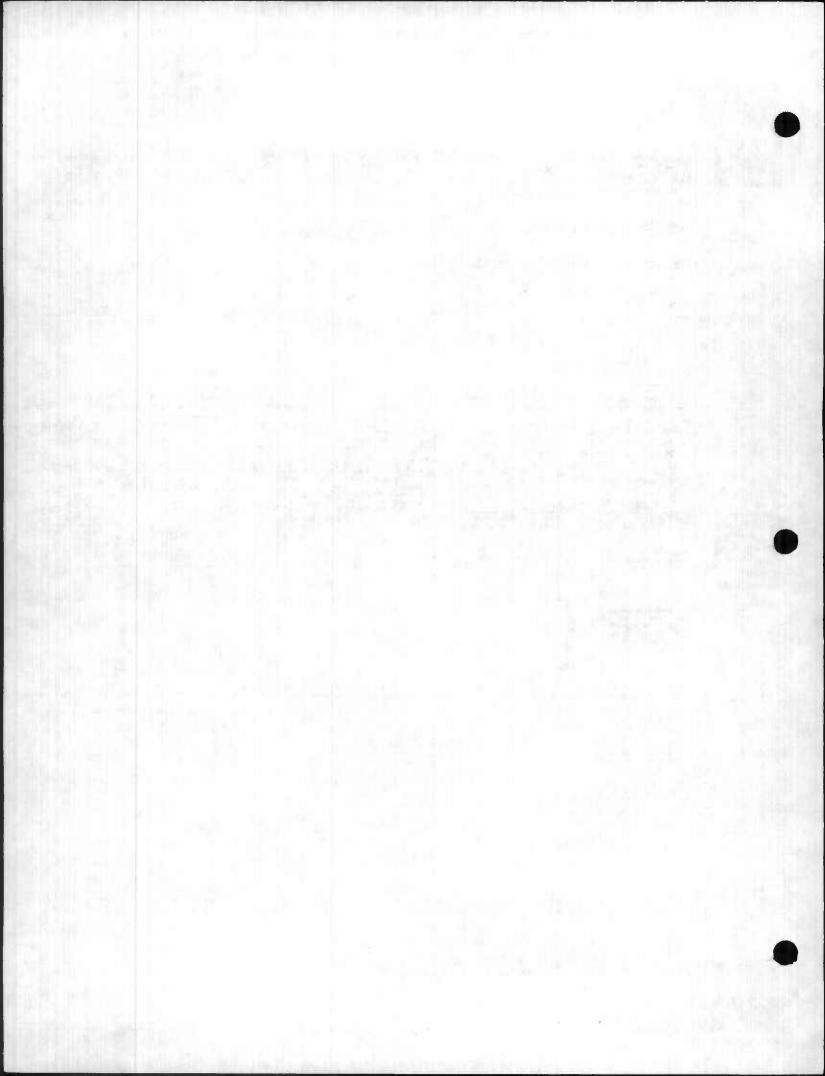
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Richard Eugene Everett

State of Maryland / Department of Health and Mental Hygiene

		ate of Maryland /	Certificate of		Reg.		32911	
Physician	1. Decedent's Neme (First, Middle, Last)				Date of Deeth     Month	Dey	3. Time of Death	
/Medical	RICHARD &	3 INIOU	VERETT		October 1	16. 20		
Examiner	4a Fecility Name (If not institution, give street			4b. City, Town, or Lo	cation of Deeth	4c. County		
	Fallston Genera	l Hospital		Fallsto	n	Harf	ord	
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last b.	Months Dave	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day, Ye		9. Birthplaca (State or Foreign Country)	
Director	Usuel Residence of Decedent	84	Yrs.	770010	SEPT-22	1918	MARYLAND	
M M	10a. Stete 10b. County	10c. City, Tov	vn or Location				10d. Inside City Limits	
with the Marylar a or 28a-f show Libe notified at Director	MARTORI	JA	RRETTSVI	772			1 ☐ Yes 250 No	
or 28s-f s be notified	10e. Street and Number		10f. Zip Code		10g.	Citizen of W	/het Country?	
of the part of the	1406 CHROMS	HILL ROA	3016	277		2-0	Α.	
flar death r flams 23 siner must Funeral	11 Merital Status 12. W	/as Decedent Ever in U,S. rmed Forces?	13. Wes Decedent of H		cify Yes or No-		a - American Indien, k, White, etc.	
by Exa.	1 ☐ Never Merried 2 ☐ Married ↑	Yes, Give eer or Dates: W. W. III	1 ☐ Yes 25 No		110411, 010.)	Specify		
ed within 72 ho yglers. er than 'naturi it, the Medical.	15. Decedent's Education (Specify only highest grade con	168	. Decedent's Usual Occup (Give kind of work done	etion	161	b. Kind of Bu	siness/Industry	
Men and		ollege (1-4or 5+)	life. DO NOT use retired	d)				
Co the	77RS.	120	ARPENTER				rruction	
Be series	17. Father's Neme (First, Middle, Last)			18. Mother's Name	(First, Middle, Mai	den Sumem	9)	
Merrico Mic affic	3 .3 MOC	VERSTT		( ) ARI	ARET	776	An	
and all man	19e. Informent's Name/Retetionship (Type, P	rint) 19	b. Meiling Address (Street	end Number or Rura	Route Number, C	ity or Town,	State, Zip Code) 21094	
1 27 W	SANDRA E-180BS	RTS 119	38 CHROW	1 Litter	1960 JA1	RITI	IVILL LARYED	
2 2 2 2	20s. Method of Disposition  S Burial 2 Cremetion 3 Remove	camate	of Disposition (Name of ary, cremetory or other plea	ce)	Dete 200	c. Location -	City or Town, Slete	
Pages ment of ury or o	4 □ Donetion 5 □ Other (Specify)	W. LOW STORE	ion ami			LA'iR	MARYLAND	
A Party St	21. Signature of Fugeral Selection Liberises	)	22. Name and Addre			an A	ie CA.	
88252	DI WOOD VICIN		22. Name and Addres	MERALO	HAPL	-W.	1 Coort 2000	
	23a. Pert1. Enter the diseese, or complication shock, or heart faiture. List only one complications are complicated as the complex of the com	is that caused the deeth. Do	not enter the mode of dyin	ng, such es cardiac o	r respiretory errest	3/ 1/17	Approximete	
hysician	snock, or neart faiture. List only one on	on each line.					tntervet Between Onset end Deeth	
Medical	Immediate Cause (Final	Checkan	1 161	1 T.				
xaminer	disease or condition resulting in deeth)	CMEST W	od Abdomii	nal Ing	uries		1	
je line		Due to (or es e	consequence or).	U				
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iclan and buriel-transit	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	555 15 (51 55)						
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0 0	resulting in deeth) Lest							
d by the attending letached for use es	d							
the att hed for	Pert It. Other etgnificant conditions contribut	ing to death but not resulting	in the underlying cause giv	en in Pert I.	23b. Did tobe	cco use con	tribute to the cause of death?	
detached detached							3 Probably 4 Unknown	
be de be de								
been sig should b					24a. Wes en e		24b. Were eutopsy findings evailable prior to	
s been 2 shou piete					periormed	ar .	completion of cause of death?	
ar & E					10/05	2 🗆 No	1 1 46s 2 No	
	25. Was case referred to medicat			26. Plece of Deeth		20140	100 2010	
s certification director	examiner?  1 Yes 2 No Hospit	el: 1 Inpatient 2 XER/O	utpatient 3 DOA Oth	Ar		e E 1704	or (Specify)	
2 -		a. Dete of tnjury 28b.	utpatient 3LI DOA	4 Li Nursing Hor	ne 5 Residence			
th.	1 □Naturet 5 □ Pending		Injury Wor	k? Yes 2 DANo	motor vehic			
after deeth. Director: After I in by the fune	3 Suicide 6 Could not be	e. Ptece of Injury - At home, for	TIP		8f. Location (Street	at end Numbe	er or Rural Route Number,	
HA SE	4 Homicide determined 20	building, etc. (Specify)	clas 1		City or Town, S	(tete) /22	7 Shrome Hill Rd	
	29e. Certifier 1☐ Certifying Physician	: To the best of my knowledge	a deeth occurred at the tin	ne, dete end place	Jacretisu	ine, N	19	
Fune Fune Petaly fil	(Check only 20 Medicat Examiner: C	In the basis of examination er and menner steted.	nd/or investigation, in my o	pinion, deeth occurre	d at the time, date	end pteca, e	and due to the cause(s)	
Ned A	29b. Signeture end title of cartifier		29c. Licens	e number	29d.	Dete signed	(Month, Dey, Year)	
10	D 10	1		O.C.M.E.			17, 2000	
121	denn fl	utemp					1,7 2000	
4,0	30. Name and eddress of person who complet							
	Dennis J. Chufe 31. Dete filed (Month, Day, Year)	32. Registrer's Signeture	111 Penn Sta	reet, Balt	imore, M	arylan	d 21201	
State Registrar	QCT 1 8 2000	Seneral	la 1					
	22. 2 2000	12	D. Span	Kel				
H 16 Rev 6/95								



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#4a perPHYg788 10 18/2000 EW Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Physician October Dolores H. Ellerman 10, 2000 /Medical 4a Facility Nama (If not institution, give street and number) 715 Maiden Choice La 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Apt HR 325 Charlestown Retirement Center Catonsville Baltimore 8. Date of Birth (Month, Day, Year) Feb. 25, 1 If Under 1 Year If Under 24 Hrs. Birthplaca (Stata or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 10 M 20 F Yrs. 1920 215-09-8616 80 Director Usuel Rasidence of Decedant 10a, State 10b. County 10c. City, Town or Location or 28s-f show Md. Baltimore Catonsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 급 Name 23a 715 Maiden Choice Lane Apt. H.R.325 21228 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2/☐ No If Yas, Giva Yaar or Datas: Race - Amarican Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) be filed within 72 hours after dital Hygiene. digher than "natural", or lian event, the Medical Examiner. 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: 3 Widowed 4 Divarced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10th Homemaker Home 18. Mother's Nama (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be like Department of Health and Mental Hy important: If Iban 27 is marked oth any injury or other traumatic event abis. 17. Fether's Nama (First, Middla, Last) Be Helen Granger Henry Boss 2 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Lerov Ellerman ( Husband 715 Maiden Choice Lane Apt.HR325 Catonsville, Md. 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 4 Donation 5 Dothar (Specify) 10/13/00 Baltimore, Maryland 21. Signature of Funeral Service Licensee Kevin E. Ecker 22. Name and Address of Facility. McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue Baltimore, Maryland 21225 23a. Part 1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical immediata Causa (Final renal cell carcinomo . Metastatic diseasa or condition resulting in deeth) Examiner Due to (or as a consequence of) sician and burlai-transit Sequentielly list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of):

Physician/Medical Examiner by Completed 8 Certification: To

1 Yas 2 No

5 Pending invastigation

6 Could not be datermined

27. Manner of Death

1 Naturel 2 Accidant

3 Suicide

29a. Certifier

4 - Homicide

(Check only one)

29b. Signatura and titla of certifier

filled in by

Vital Records, P.O. Box 68760 087 signed I page 2 a certificate funeral director, o this After deeth. after deeth Director:

Ellerman

Doloras

10

24 hours a

within 24 hor To the Fune completely fi

Medical

State

5

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical axaminar?

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

28a. Place of injury - At homa, farm, street, factory, office building, atc. (Specify)

26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 Yes 2 No

281. Location (Street and Number or Rural Routa Number, City or Town, Stata)

1 Yes 2 No

1 Yas 2 No

24a. Was an autopsy performed?

23b. Did tobacco use contribute to the cause of death?

OCTOBORT 11 2000

3 Probably Unknown

24b. Were autopsy findings available prior to complation of cause of death?

1 Yas 2 No

9:30 A.M.

10d. Inside City Limits

1 Yas 2 No

21228

Approximata Intervel Between Onset and Death

months

Wedical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year)

30. Nama and adrass of person who completed causa of death (Item 23a) (Type, Print)

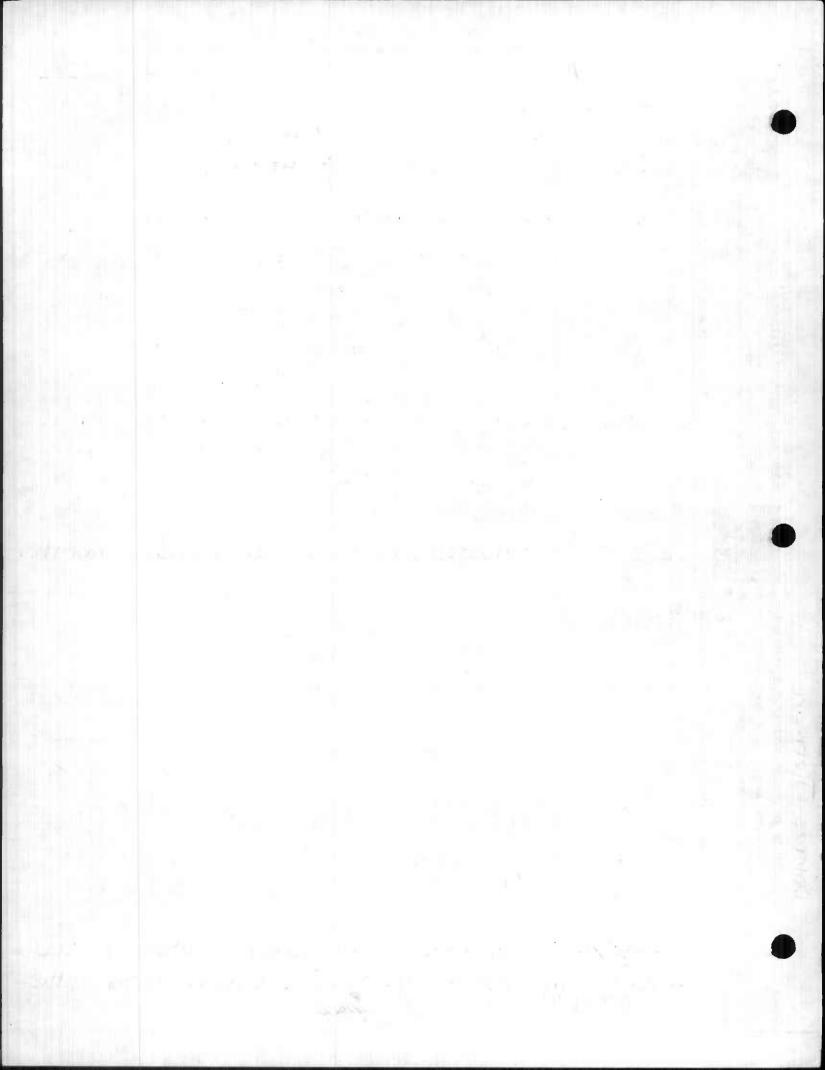
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Carpenta: Mo Carpenta: Mo CTay 1° est 2000 32. Registrar's Signatura

Maiden Choice Ln Catorbyille

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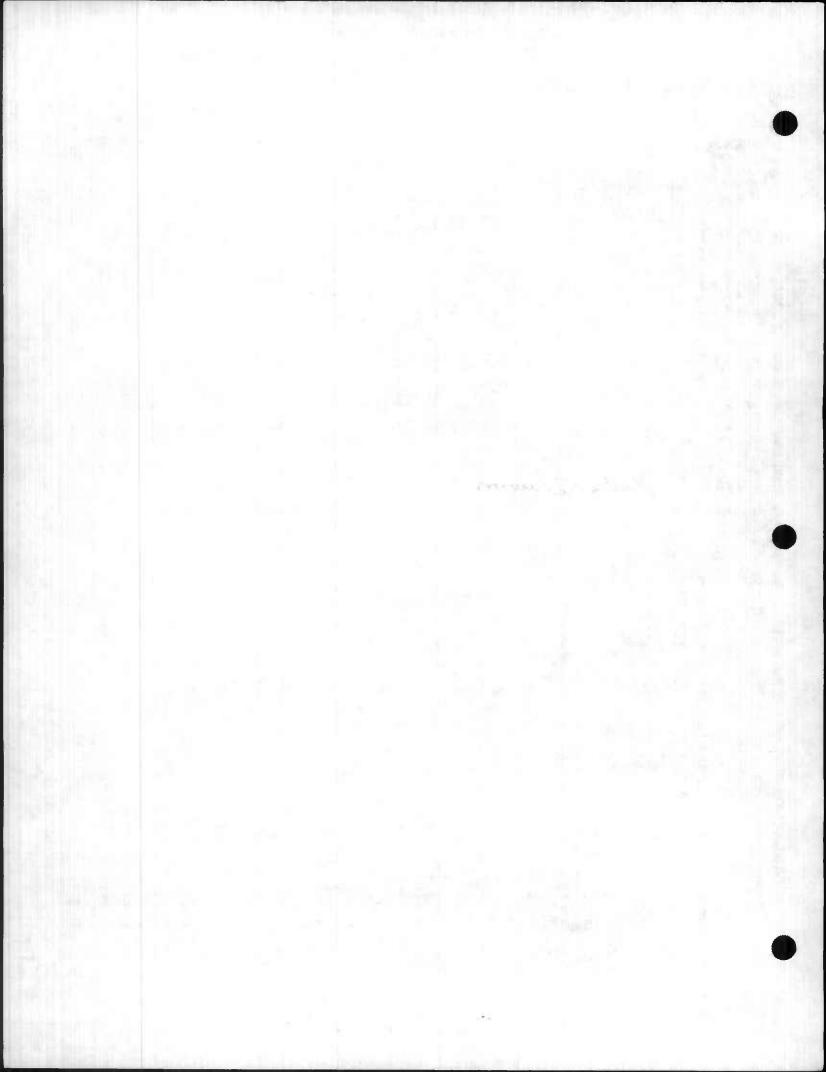
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	State of Maryland / Department of Health and Mental Hygiene []	3
	Certificate of Death	

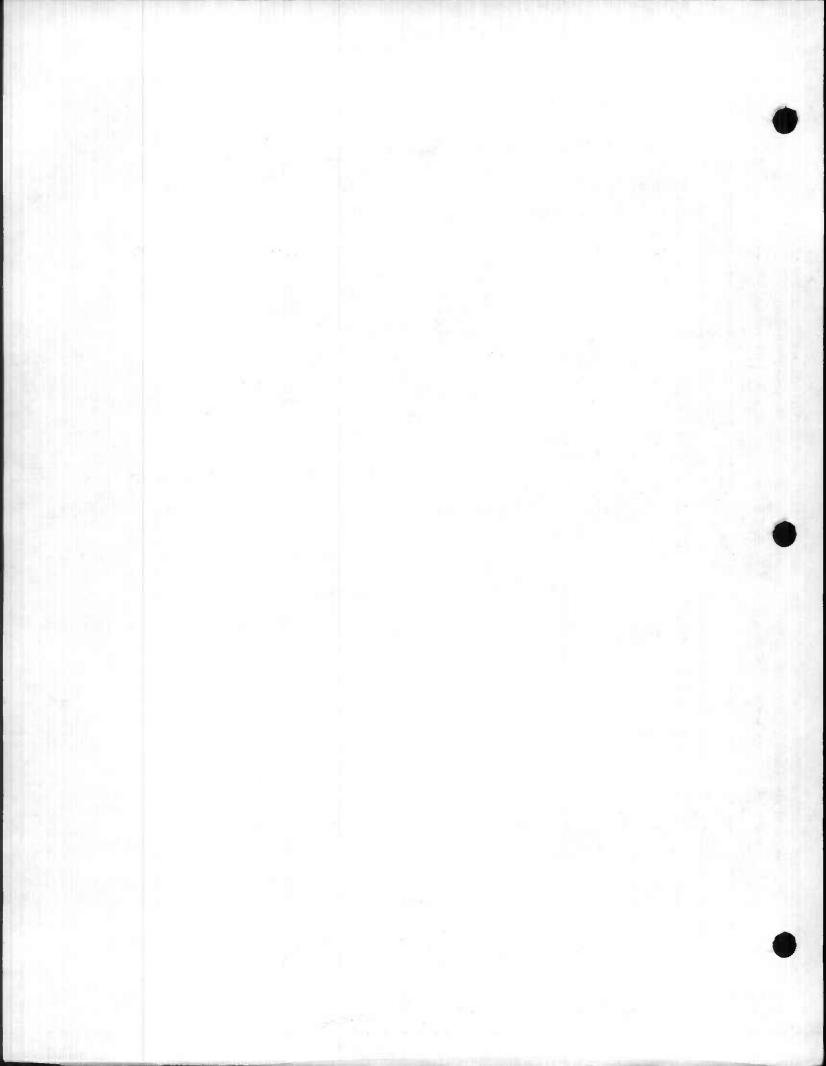
	State of Maryland / Departn  Certific	nent of Health and I cate of Death	Mental Hygiene U	32913						
-	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death						
Physician /Medical Examiner	DOROTHY CAROLYN FASTIE  4a Facility Name (If not institution, give street and number)	4b. City, Town, or	October 13,	2000 7:15 P.M.						
20	Blakehurst Retirement Community	Towso		more County						
Funeral Director	098-22-6618 1□M 2NF 85 Yrs. Mo	Under 1 Year If Under 24 Hrs. Inths Deys Hours Min.	8. Dete of Birth (Month, Day, Year) Sept 17, 191	9. Birthplace (State or Foreign Country)  Maryland						
and **	Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	n		10d. Inside City Limits						
Marylan H show	Maryland Baltimore County Tows	on		1 ☐ Yes 2 X No						
or 28s	10e. Street and Number 10	Of. Zip Code	10g. Citizen of t	What Country?						
23a c	1055 W. Joppa Road	21204		USA						
1215-0020 within 72 hours after death with the Maryland and. Then 'netural', or items 23a or 28a-f show the Marical Experience must be notified an implementation of the contract of the contr	1 Never Married 2 Married 1 Yes 2 No	Decedent of Hispanic Origin? (S s, specify Cuban, Mexican, Puerl res 2 XNo Specify:	Specify Yes or No- to Rican, etc.)  14. Rec Blac Specify	ve - American Indian, ck, White, etc. v: White						
1 21215-0020 ed within 72 hours att ygians att ygians ar than "nefural", or the than the deciral Example Completed by F	(Specify only highest grade completed) (Give kind	s Usual Occupation of work done during most of wor IOT use retired)	rking 16b. Kind of B	usiness/Industry						
Maryland 212. d 2 should be filed within in and Mentel Pyglene. I la marked other than traumatic avant, the M.		entary Teacher	Music	c Education						
be file doth doth Be	17. Father's Name (First, Middle, Last)		me (First, Middle, Maiden Sumen							
Maryland d 2 should be fill th and Mentel Hy 7 le marked oth traumatic avan	William Ferdinand Fastie	Caroly		9						
C = 0 +	William H. Fastie (Nephew) 7110 S	heffield Road,	Baltimore, Mar Date 20c. Location							
altimore, mir. Pages 1 e partmant of Hae portant: If flam y Injury or othe	1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)  Loudon Park		.0/21/2000 Balti	imore Maryland						
Baltimo	21. Signature of Funeral Service Liganosis 22. Nat	me and Address of Facility	1 77 1 77	-						
D See See See See See See See See See Se	Martin D. Lawson (MOO358) Mit	Chell-Wiedefeld O York Road B	d Funeral Home,	Inc. and 21212						
	Martin D. Lawson (M00358) 650  23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardia	c or respiratory errest,	Approximate Interval Between Onset and Deeth						
Physician / /Medical / Examiner	Immediate Cause (Final disease or condition a. Partial bould for setting in death)	obstruct.	/							
250 KW	Due to (or as e consequence			6 weeks						
executed n and ial-trensit	Sequentially list conditions  b. Metastatic (Lon  Due to (or as a consequence	Cancer ce of):		Gueens						
D & G	If any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events Due to (or as a consequence)	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events Due to (or as e consequenca of):								
P.O. Box 68760, that the death cartificata be end by the attending physician detached for use as the buria	d									
o dea e dea the att the att	Part II. Other significant conditions contributing to death but not resulting in the under	ylng cause given in Part I.	23b. Did tobacco use co	entribute to the cause of death?						
P.O. hat the od by the detache	preumonitis		1 ☐ Yes 2 ☐ No	3 Probably 4 Upknown						
cords, requires to been sign should be		18540	24a. Was an autopsy performed?	24b. Were autopsy findings eveilable prior to completion of cause of death?						
Vital Relationary Vital Relations of the law certificate has rector, page 2			1□ Yes 2⊟No	1 Tyes 2 No						
Artifica setor, p	25. Was case referred to medical	26. Place of De	ath (Check only one)							
Of Vita Physician: this certific ral director,	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other: 4 Nursing F	Home 5 ☐ Residenca 6 ☐ Ott	ner (Specify)						
Division o within 24 hours after death. within 24 hours after death. to the Funeral Director: After th completely filled in by the funeral	27. Menner of Death  1 Tratural 5 Pending (Month, Day Year)  2 Accident Sulcide 6 Could not be	28c. Injury at Work?  1 □ Yes 2 □ No	28d. Describe how injury occur							
Division To the Hospital or Attending is within 24 hours after death To the Funeral Director: After completely filled in by the fune. Medical Certification	3 ☐ Sulcide 6 ☐ Could not be determined 28e. Placa of Injury - At home, farm, street, f building, etc. (Specify)	actory, office	28f. Location (Street and Numi City or Town, State)	ber or Hural Houte Number,						
To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occ process of the death occ									
T T T T T T T T T T T T T T T T T T T	29b. Signature and title of cartifier	D3272	1 /	od (Month, Dey, Year)						
10/17	30. Name and address of person who completed cause of death (Nem 23a) (Type, Print Joseph Adams, M.D., 6565 North Charle		on, Maryland 21	204						
State Registrar	31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture	g spars								
DHMH 16 Rev 6/95	OCT 1 8 2000   Senera /	jopenes								

ORIGINAL.



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 29 | 1 | State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Yee **Physician** 5:42 Am BABY GIRL FROMMEYER 7,2000 ctober /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, giva street and number) 4c. County of Deeth Examiner H Under 24 Hrs. 8. Data of Birth (Month, Day, Year)
Oct 7, 2000 Baltimore Franklin Square Hospital Center If Under 1 Year 5. Social Security Number NONE Birthplaca (Stete or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□ M 2\ F Days Director MD Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or Itams 23s or 28s-f show other traumetic event, the Medical Examinar must be notified at MD Baltimore Baltimore 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1921 Midland Road 21222 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, etc. 1 Nevar Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be flied w
Department of Health and Mental Hygien
Important: if Item 27 is marked other th
any Injury or other traumeth none none none none 17. Fathar's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) 8 Georgia Parry Ron Frommeyer 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Georgia Parry/mother 1921 Midland Road Baltimore, MD 21222 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Date 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 🖾 Other (Specify) 21 Signature of Fineral Service Licenses Wade, Director State Anatomy Board 655 W. Baltimore Street timula 21201 Baltimore, MD 23e. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert teilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Finel Prematurity diseese or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner Subarachnoid Hemorrhage physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Respiratory Distress with No Evidence of Aeration of Lungs
Due to (or es e consequence of): Box 68760, Physician/Medical P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Vee 2 No 3 Probably 4 Onknown signed l Records. þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed certificate of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 1 Neturel 2 Accident Attending 5 Pending s after des. 1 Yes 2 No investigation 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, tarm, street, tectory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Direc completely filled in b 6 Hospital edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) end menner es steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only To the Pwithin 2 29b. Signeture end title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) 10/7 22511 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Sita Kottapalli MD Square Drive Baltimore Maryland 21237 31. Dete tiled (Month, Day, Year) 32. Registrar's Signature State Black 007 1 8 ZOOD Registrar



State of Maryland / Department of Health and Mental Hygiene

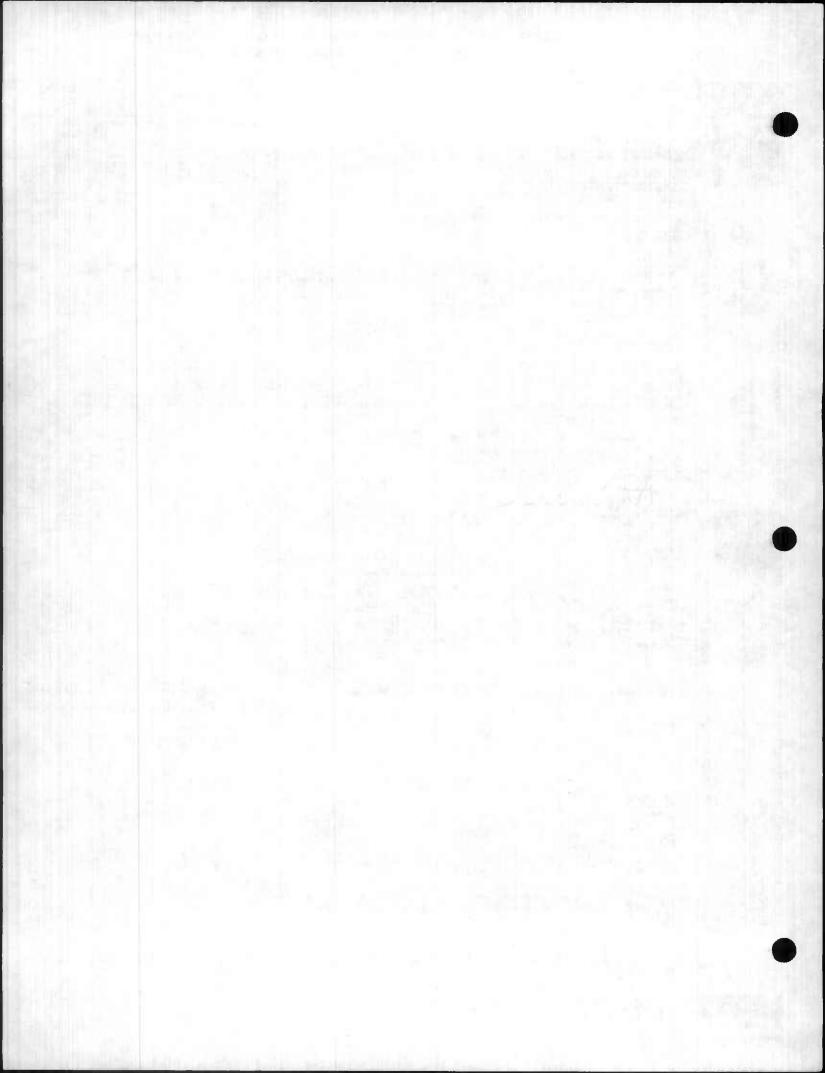
Certificate of Death

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Director	Usual Residence of Decedent	00				Mal.20	1112	FC	
Aland Mand	10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10	d. Inside City Limits
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S or S	10e. Street and Number	N		10f. Zip Code 2 1 2 2			10g. Citizen of V USA	Whet Count	ry?
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us after death vil. or hams 23 Confider must		12. Was Decedent Evar in U Armed Forces? 1 ☐ Yes 2 5000 if Yes, Give Yaar or Datas:		Was Decedent of f Yes, specify Cul 1  Yes 2 No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)  14. Raca - Al Black, W			itc.
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mit. Pages 1 ar partment of thea portant: if them 2 y Injury or other ca.	20a. Method of Disposition  1 □ Burlel 2 □ Cremation 3 □ 4 □ Donetion 5 □ Other (Special	20b. I Removal from State	Place of Dispo	esition (Neme of metory or other pl	ece) O	Date ct 21 2000	20c. Location -		
Certificate be assected from the following physician and from the following physician and from the following physician and from the following physician is a following physician	Cause (Diseese or injury that initiated events resulting in death) Lest	a. Subara Due to (	Do not ent	110 Solder the mode of dy and a colder the mode of dy	ring, such as cardiac	int Rd or respiretory as	Dunc rest,		Md 2122 Approximate Interval Between Onset and Death
		dcontributing to death but not re-	sulting in the u	nderlying cause g	given in Pert I.	23b. Did	tobacco use co	ntribute to	the cause of death?
thet the death ed by the atternation of the control	Cerebrovas	cular di	seas	se,		10	Yes 2 No	3 Prot	bebly 4 Unknown
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Physician: this certific ral director, To Ba	examiner?	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA	ther: 4 Nursing H	ome 5 Resid	denca 6 □Oth	er (Specifi	()
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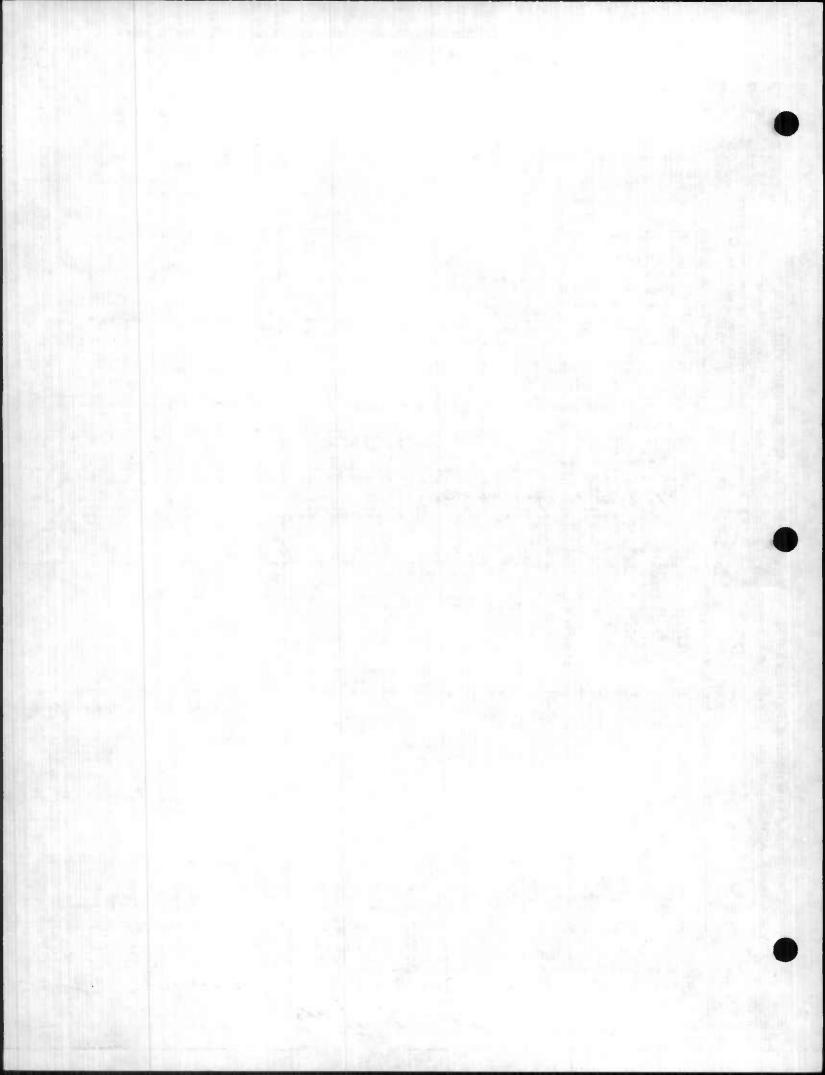
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Directo	10e. Street and Number	AKUNDI	CL	GLE	N BUK	10f. Zip Code				10g. Citizen of V	Mhat Countr	
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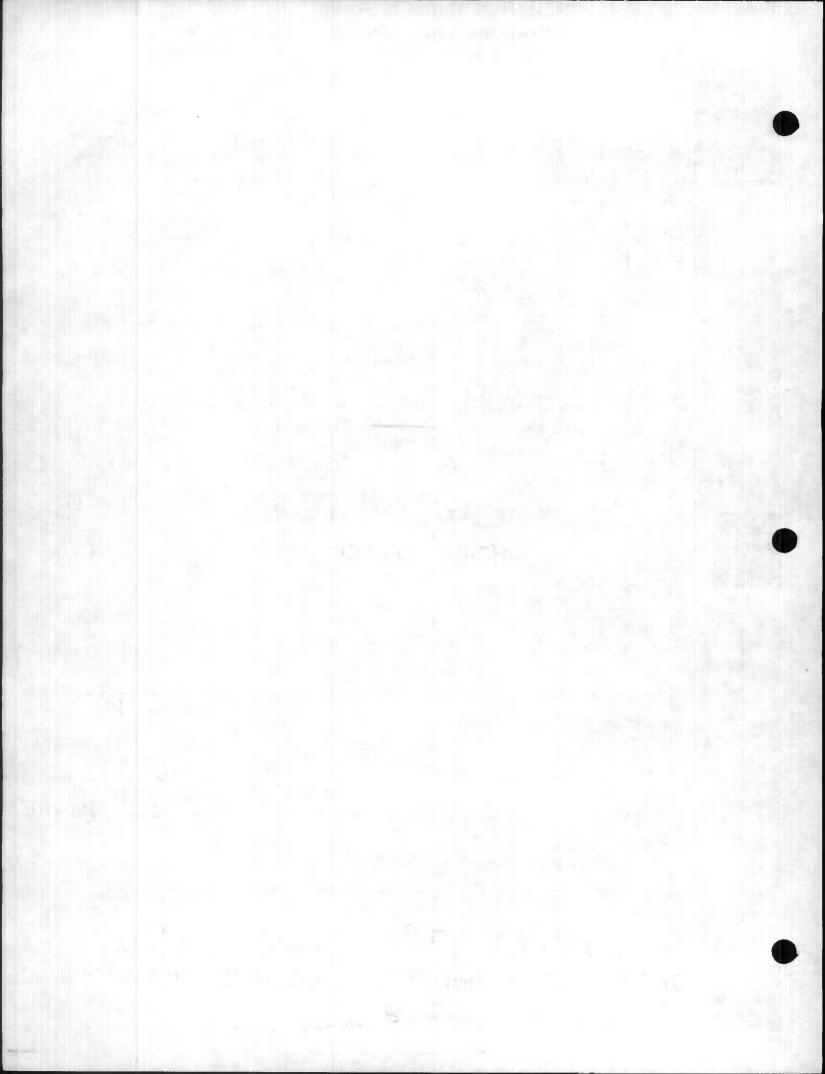
State of Maryland / Department of Health and Mental Hygiene

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ilei	Stella Ma	ris at	Mercy H	osnita	a 1			Balti	more			n/a		
	5. Social Security Num		Sex	-	yrs. last birthday	) If Undar 1	Yaar	If Under	24 Hrs.	8. Date of Bi (Month, D			9. Birthpl	laca (State or Forei
М	214-22-270	7	1⊠M 2□ F		72 Yrs.	Months D	Days	Hours	Min.	4/25/1	928	М	Coun.	ny) and
	Usual Residence of D	-		l .				ll		.,, _		1.00		
	10a. State 1	10b. County		10c.	City, Town or I	Location							10	0d. Inside City Limi
ò	MD	n/a				Balti	imo	re						1 XYes 2□ñ
Director	10a. Street and Numb	per			7.316	10f. Zip Co	ode				10g. Citiz	zan of Wh	nat Coun	try?
2	155 South	h Grundy	Stree	t. Apt.	. 111	21	122	4	USA					
runeral	11. Marital Status		12. Was Dec				nt of Hispanic Origin? (Specify Yas							an Indian.
	1 Never Married	2071 Marriad	Armed F	ned Forces? If Yes, specify (  ] Yes 2 ☑ No				n, Maxican	, Puerto	Rican, etc.)			White,	
	3 Widowed 4		If Yes, G	Yes, Give 1 ☐ Yes 2 🗵 ar or Dates:				Specify:				Specify:	Whi	te
-		5. Decedent's E			16a Dec	Decedent's Usual Occupation					16h Kin	nd of Busi	iness/Ind	lustry
	(Specify	only highest gr	ade completed)	1	(Giv	a kind of work of DO NOT usa	d of work done during most of working							
	Elementary/Second		Collega (	(1-4or 5+)	_	llet Ma		•			Tirs	chma	n Lu	umber Co.
	6 t l		1									Sumama	1	
1	Frank	18. Mother's Name (First, Middle, Maiden Surname) Mildred Bievens												
19e. Informant's Name/Relationship (Type, Print) Wife 19b. Mailing Address (Street and Number or F									er or Run	al Route Numi	ber, Cify or	r Town, St	tate, Zip	Code)
	Mary Fisch				155	S. Grun	ndy	St.	Apt.	111,	Balti	more	, MI	21224 wn, Stata
	20a. Method of Dispos		Demovel from		b. Place of Disp cemetery, cri	position (Name ematory or othe	of er plec	e)						
	4 Donation 5			C	Greenmou	ınt			TC	0/18/200	Balt	imore,	, Mar	yland
	21. Signeture of Fune	eral Sarvice Lice	nsee			22. Name and A	Addres	ss of Facilit	y Jose	eph N. Z	annino	Tr. I	Finer	al Home
	Mar	in by	Zare	new		63 South								
-	23a. Part1. Enter the shock, or heart	disass or not	offications that	caused the c								1.425		Approximate
of for use as the buttal-transit and and and and and all and	Immediata Cause (Fi disease or condition resulting in death)	inal	. Me	tas)	alto lo (or as a cons	de	in		^	noes	•		1	Interval Between Onset and Death
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The same name and a second nam	disease or condition resulting in death)  Sequentially list condition, leading to imm cause. Enter Undarty Ceuse (Disease or in that intitated events	litions, lediate lediate ing jury st	a. Me	Due t	do (or as a conse	equence of): equence of):	in	9	Pa	nols 23b. Die			ribute to	Onset and Death
	disease or condition resulting in death)  Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in that initiated events resulting in death) La	litions, lediate lediate ing jury st	a. Me	Due t	do (or as a conse	equence of): equence of):	in	9	Pa	23b. Die	d tobecco	□ No 3	3 Prot	o the cause of dear
	disease or condition resulting in death)  Sequentially list cond if any, leading to imm cause. Enter Underly Ceuse (Disease or in that initiated events resulting in death) La	litions, lediate lediate ing jury st	a. Miles	Due t	do (or as a conse	equence of): equence of):	in	9	Pa	23b. Dic	d tobacco	□ No 3	24b. We	Onset and Death
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	disease or condition resulting in death)  Sequentially list cond if any, leading to imm cause. Enter Underly Ceuse (Disease or in that initiated events resulting in death) La	litions, lediate ring jury st	a. Me	Due t	do (or as a conse	equence of): equence of):	in	en in Part I	20	23b. Dic 1 = 24a. Wa per	d tobacco   Yes 2   Yes 2   Yes 2	□ No 3	24b. We ave	o the cause of dear bebly 4 Unknown allabe prior to mpletion of causa
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edical Certification: To Be Completed by Physician/Medical Examiner	disease or condition resulting in death)  Sequentially list cond if any, leading to imm cause. Enter Undark Ceuse (Disease or in that initiated events resulting in death) La  Part II. Other eignification of the condition of the	d to medical  S Pending Invastigatio  C Could not be	Hospital:    28a. Date   More	Due to Du	to (or as a consist to (or	equence of): equence of): equence of): underlying cause underlying cause  ent 3 DOA of 28c M  ath occurred et 1	Othorse give	26. Place er: 4 Nu y at k? Yes 2 I	Od)  of Deat ursing Ho  No	23b. Did 1 24a. Wa per 1 1 Check only me 5 Res 28d. Describe 28f. Location City or To	s an autopformed?  Yes 25 one) Stidence 6 how injury (Street amown, State) a cause(s)	No Solver y occurred d Number	24b. We ave color of the color	othe cause of dear bebly 4 Junkner autopsy finding aliable prior to mplation of causa deeth?  Yes 2 No RIS AT I
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commencer to be completed by injurial	disease or condition resulting in death)  Sequentially list cond if any, leading to imm cause. Enter Undart, Ceuse (Disease or in that intilated events resulting in death) La  Part II. Other eignification of Death 1   Natural 2   Accident 3   Suicide 4   Homicide    29a. Certifier (Check only one)	d to medical  S Pending Invastigatio Could not be determined  Certifying Pt Medical Examined	Hospital: 1   28a. Date (Mori Mori Mori Mori Mori Mori Mori Mori	Due to Du	to (or as a consect to (or	equence of):  equence of):  equence of):  underlying cause  ent 3 DOA  of 28c  M  street, factory, of  ath occurred et investigation, in  29c. L  D	Other Street Control of the time of time of the time of the time of time of th	26. Place er: 4 Nu y at k? Yes 2 ne, dete en pinion, dee	Od)  of Deat ursing Ho  No	23b. Did 1 24a. Wa per 1 1 28d. Describe 28d. Describe 28f. Location City or To	s an autopformed?  Yes 25 one) Street and own, State)  a cause(s)  date and  29d. Date	No Solution No Sol	24b. We ave con of the control of th	othe cause of dear pably 4 Unknown and pably 4 Unknown and pable of causa death?  Yes 2 No RAS AT ANY HOS PASS  All Route Number, lated othe cause(s)

ORIGINAL

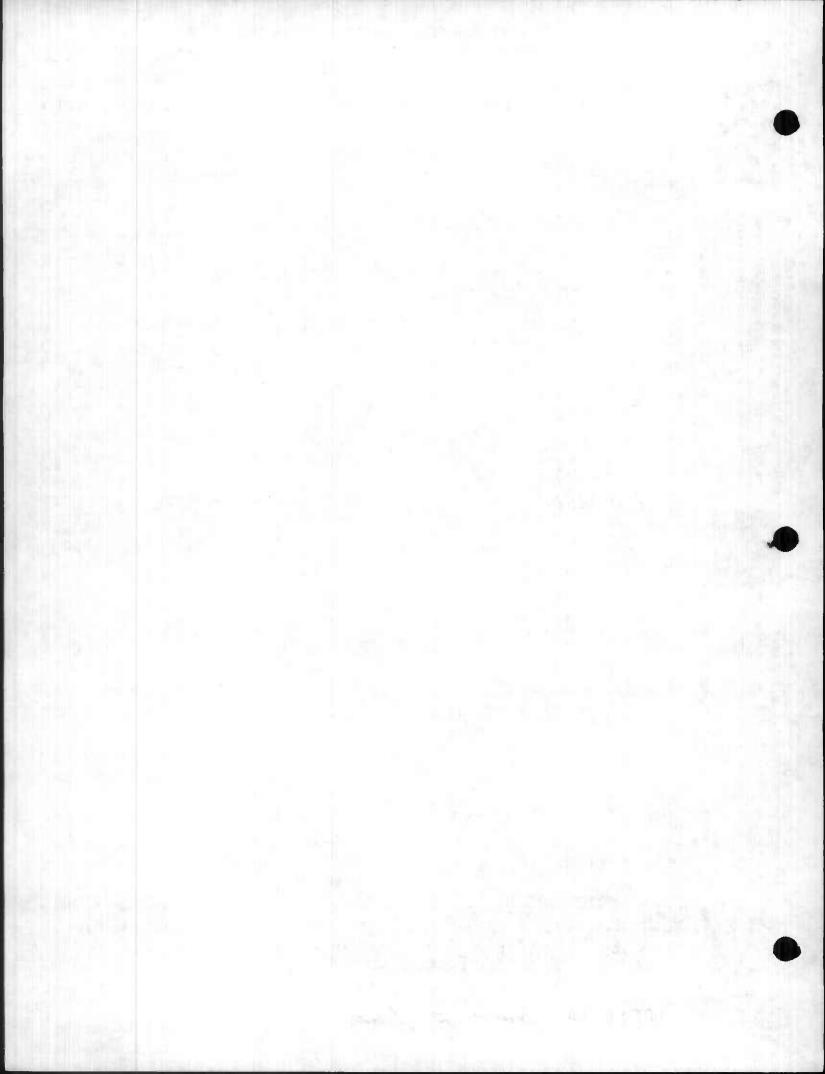


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#19b perFHG788 10/18/2000 EW Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year **Physician** 14, 2000 4c. County of Death 12:20 PM CTO /Medical 4b. City, Town, or Location of Deeth Facility Name (ff not institution, give street and number) Examiner more 8. Date of Birth (Month, Dey If Under 1 Ye 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days -9943 Hours 1 M 2 F Months Yrs Director Usual Residence of Decedent 10a State 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 XYes 2 No by Funeral Director Maryland 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt ä 21 rove Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates: 11. Merital Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece · American Indian. Black, White, etc. 1 Never Married 2 Married b 1□ Yes 2 No Specify 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of 19a. Informant's Name/Relationship (Type, Print) (hiece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peges 1 and 2 is ment of Health ar s.Matti Department of Health important: If Item 27 Is any injury or other 20b. Place of Disposition (Name of cemetery, grematory or other place) 20e. Method of Disposition Date 20c. Location -City or Town, Stete 10/20/2000 Burial 2 Cremetion 3 Removel from State Donation 5 Other (Specify) Cemetery voodlawn 22. Name and Address of Facility / Joseph L. Russ 2222 W. North Funeral Home ve. Balto. Md. Joseph 2222 any 21216 Ave. Approximate Interval Between Onset and Death Enter the divises or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. **Physician** GABTRIC Immediate Cause (Final disease or condition resulting in death) /Medical mo Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 □ Unknown 3 1 ☐ Yes 2 ☐ No Be Completed by 24a. Wes an eutopsy performed? 24b. Were autopsy findings eveilable prior to completion of cause of death? has page 2 2 No 1 Yes 1 Yes 2 No this certificate of Vital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 6 Dother (Specify) HOSPICE Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 2 No Medical Certification: To 1 Yes 5 Residence 28c. Injury at Work? 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Division After 5 Pending investigation 1 Natural after death. 1 Yes 2 No 2 Accident the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homlcide To the Hospital of within 24 hours a To the Funerel D 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture end title of certain 29d. Date signed (Month, Dey, Year) BATIMORE MO 21204 CYMUE 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Registrar



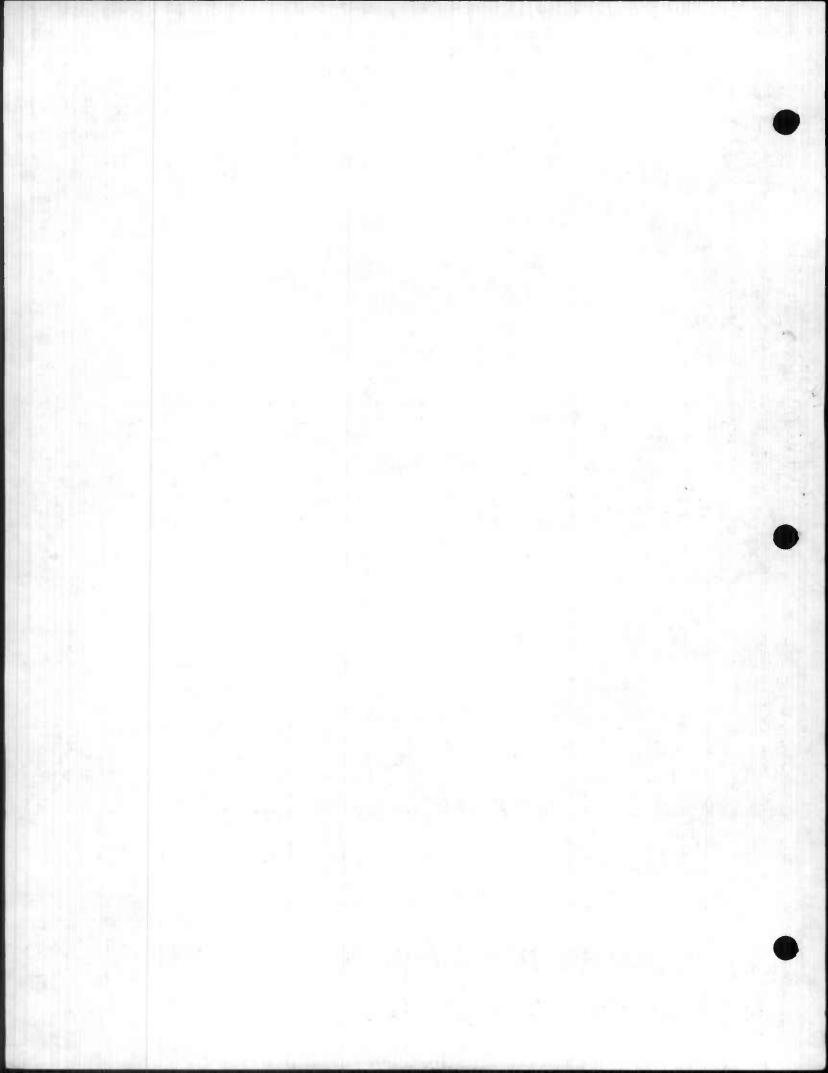
State of Maryland / Department of Health and Mental Hygiene 0 0 329 | 9

11/61/21/21/21	1. Decedent's Name (First, Middle,					2. Dete of Deat Month	Dey Yee	
nysician Medical	EDWIN	DAVID		GLICKMAN		OCTOBER	15, 2000	2:40 AM
xaminer	4e Fecility Neme (If not institution, g BRIGHTWOOD ME		ING HOME	3	4b. City, Town, or L LUTHERVI		4c. County of De	
neral ector	5. Sociel Security Number 218–28–1649  Usuel Residence of Decedent	. Sex 7. Age 1XIM 2□ F	(In yrs. lest birthd 68 Yrs	Months Devs		8. Date of Birth (Month, Day, OCT • 11	,1932 9. B	irthplece (State or Fore Country) MD
Director	10a. Stete 10b. County		10c. City, Town o	r Location				10d. Inside City Lim
Director	MD BALTIM	ORE	BALTIMO					1 □ Yes 2X
al Dire	10e. Street and Number 6728 CHOKEBERRS	Y ROAD		10f. Zip Code	21209	10	U.S.A.	Country?
by Funeral	11. Meritel Stetus  1 Never Merried 2 Merried  3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1 12 Yes 2 No If Yes, Give Yeer or Dates:	ver in U,S.	<ol> <li>Wes Decedent of If Yes, specify Cub</li> <li>Yes 2XNo</li> </ol>		pecify Yes or No- pecify Yes or No- pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Raca - An Bleck, Wh Specify:	nerican Indien, nite, etc. WHITE
Completed	15. Decedent's (Specify only highest of Elementery/Secondery (0-12)	Education grade completed)  College (1-4or 5+	) (G	ecedent's Usuel Occulive kind of work done to DO NOT use ratirs	during most of work	king	16b. Kind of Busines	RE COMPANY
Be Co	17. Fether's Neme (First, Middle, La	-	FROE	KILLOK	18. Mother's Nem	ne (First, Middle, N		RE COMPANY
To B	JEROME		GLICK	MAN	CECELIA			SACKS
	19e. Informant's Neme/Reletionship MARCIA GLICKMA		672	eiling Address (Stree 28 CHOKEBEI	RRY ROAD			
	20e. Method of Disposition 1   ☐ Burial 2 □ Cremetion 3 4 □ Donetion 5 □ Other (Special Contents)			sposition (Neme of cremetory or other ple			REISTER	STOWN, MD
ian cal ner saminer	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	e	ne deeth. Do not	SONS	ing, such es cardiac	or respiratory erre		Approximete Intervel Between Onset and Death
edic	Cause (Disease or injury that initleted events resulting in death) Lest	d	ue to (or es e con		ven in Pert I	23b. Did to	bacco usa contribu	Ite to the cause of de
Icla	Pert II. Other elgnificant conditions			o stroom, and source a				
y Physician/M	Pert II. Other elgnificant conditions  DEW	ENTI	A			1 🗆 Ye	e 2□No 3□	Probably 4 Unkr
p A	Pert II. Other elgnificant conditions  DEW	CHTI.	A			1 ☐ Ye	n eutopsy 24t	o. Were eutopsy finding
pege 2 should be d	Den	CHTI	A			24a. Wes er	n eutopsy 24t	Were eutopsy finding eveilable prior to completion of cause
pege 2 should be d	25. Was case referred to medical examiner?	Hospitel: 1   Inpatient		Itlent 3LI DOA	her: 4 Nursing H	24a. Wes er perform  1  Ye th (Check only only only only only only only only	n eutopsy 24th ed?  s 2 1 No	b. Were eutopsy finding eveilable prior to completion of cause of death?
pege 2 should be d	25. Was case referred to medical examiner?  1 Yes 20 No  27. Manuel 5 Panding investigati	28e. Dete of Injury (Month, Day )	Year) 28b. Tim Inju	e of 28c. Injury M 1	her: 4 Nursing H	24a. Wes er perform  1  Ye th (Check only one ome 5 Reside 28d. Describe ho	n eutopsy 24b 1907 1907 1907 1907 1907 1907 1907 1907	b. Were eutopsy finding eveilable prior to completion of cause of death?  1 Yes 2 100 2 2 100
led in by the funeral director, pege 2 should be detached Certification: To Be Completed by Physi	25. Was case referred to medical examiner?  1 Yes 20 No  27 Accident investigate 6 Could not determine	28e. Plece of Injury building, etc.	Year) 28b. Tim Injury - At home, ferm, (Specify)	e of 28c. Injury M 1 C	her: 4 Mi Nursing H iny at ink? ] Yes 2 □ No	24a. Wes er perform  1  Ye  th (Check only one one 5 Reside 28d. Describe ho  28f. Location (St. City or Town	n eutopsy 24th ed?  s 2 No  s 2 No  nca 6 Other (Sp w injury occurred  raet end Number or , Stete)	Decity)  Decity  Dec
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page 2 should be d	25. Was case referred to medical examiner?  1 Yes 2 No  7 Manual investigate 6 Could not determine 4 Homicide  29e. Certifier (Check only 2 Medical Example)	28e. Dete of Injury (Month, Day) 28e. Plece of Injury building, etc.  Physician: To the bast of aminer: On the basts of e	Year) 28b. Tim Injuly - At home, ferm, (Specify) my knowledge, do xaminetion end/o	e of 28c. Injury Wo 1 street, factory, offica	her: 4 Nursing H iny at ork?  ) Yes 2 No  me, date end plece opinion, deeth occur	24a. Wes er perform  1 Ye th (Check only one one 5 Reside 28d. Describe ho  28f. Location (Str. City or Town), end due to the cerred at the time, de	s 2 No  s 2 No	b. Were eutopsy finding eveilable prior to completion of cause of death?  1 Yes 2 No pecify)  Rural Route Number, es stated. ue to the cause(s)
npietely filled in by the funeral director, pege 2 should be detached.  Aedical Certification: To Be Completed by Physi	25. Was case referred to medical examiner?  1   Yes   20 No  7 Manage Could not determine to det	28e. Dete of Injury (Month, Dey ) 28e. Plece of Injury building, etc.  Physician: To the best of end menner stele	Year) 28b. Tim Injury - At home, ferm, (Specify) my knowledge, de xaminetion end/ord.	e of 28c. Injury Wo M 1 C. street, factory, offica	her: 4 Nursing H iny at ork?  ) Yes 2 No  me, date end plece opinion, deeth occur	24a. Wes er perform  1 Ye th (Check only one one 5 Reside 28d. Describe ho  28f. Location (Str. City or Town), end due to the cerred at the time, de	n eutopsy 124b 125 125 125 125 125 125 125 125 125 125	b. Were eutopsy finding eveilable prior to completion of cause of death?  1 Yes 2 Mo  Pecify)  Rural Route Number, es stated. ue to the cause(s)



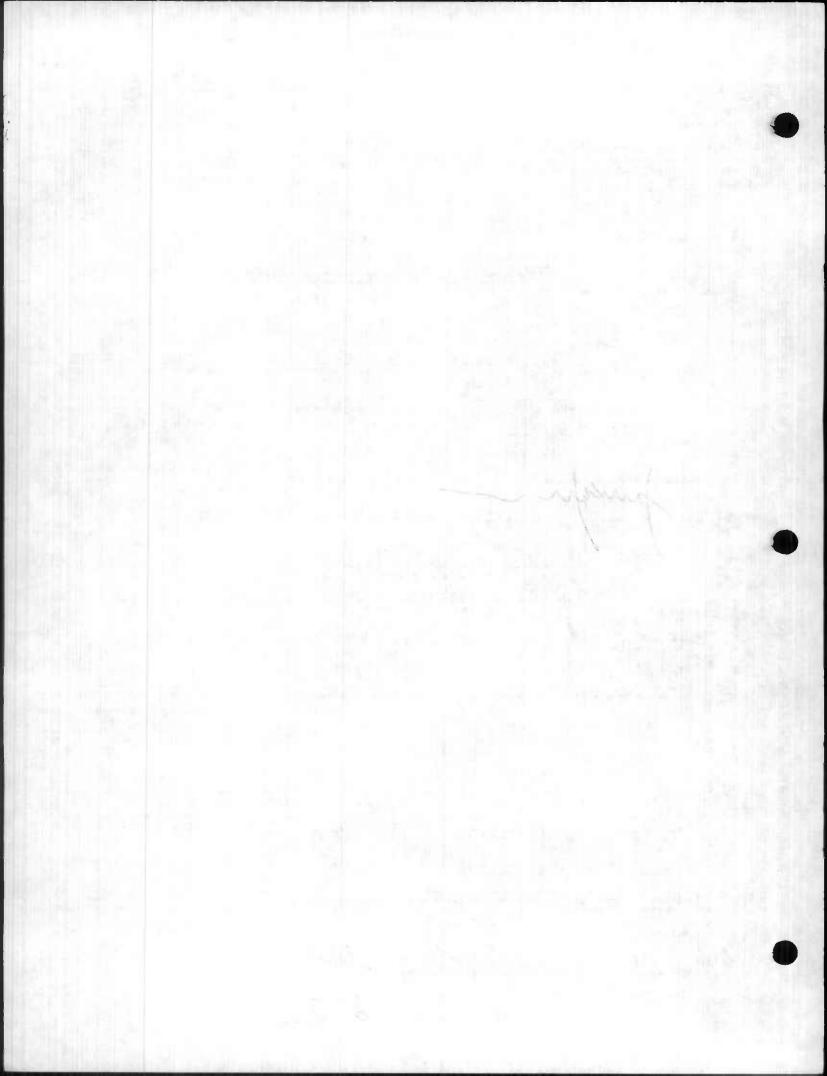
State of Manyland / Department of Health and Mental Hygiene O. O.

- 1200	AMEND#17 PER F.H. G788 10-18-2000 .	JAB Certificate of Death	Reg. No.  2. Date of Death  3. Time of Death
Physicia	JACOB	GLUSHAKOW	Month Dey Year G OI On
/Medica Examine	to English Name (If not in this tion also stood and as mine)	4b. City, Town, or	
LAGITITIC	Sinai of Baltimor	Baltin	N/A
Funeral Director		s. last birthday) If Under 1 Yeer If Under 24 Hrs.  Months Days Hours Min.	
Di Bu	Usuel Residence of Decedent   10a. State   10b. County   10c. C	City, Town or Location	10d. Inside City Limits
Mary and sh	MD N/A B	ALTIMORE	1⊠ Yes 2□No
oth with the Marylar 23a or 21a-f show unit be notified at		10f. Zip Code 21209	10g. Citizen of Whet Country? U.S.A.
	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuben, Mexican, Puerl 1 ☐ Yes 2 🌠 No Specify:	pecify Yes or No- o Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: WHTTE
21215-0 ed within 72 ho yglene. wer then "neturn 4, the Medical.	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  ARTIST	rking 16b. Kind of Business/Industry  ART
D SHOP	17. Father's Name (First, Middle, Last)  DAVID		ne (First, Middle, Maiden Surname)  NOVIKOV
hould Men	19a. Intormant's Name/Relationship (Type, Print)		ural Route Number, City or Town, State, Zip Code)
Manual Strate of trans	RIVA NOVEY / WIFE	1920 SOUTH ROAD - BALT	
nore talken or other	1 Buriat 2 2 Cometion 3 Removal from State	Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
nit. Pa artmo- octant injury	4 Donation Cother (Specify)	22. Name and Address of Facility	10/16/00 TOWSON, MD
Depa Impo	* / // Truce	8900 REISTERSTOWN F	SOL LEVINSON & BROS., INC. ROAD - PIKESVILLE, MD 21208
	284 Part Enter the disease of complication staff ceused the de shock, or heart failure. List poly one gave on each line.		
Physician /Medical Examiner	Due to	tion Pneumon (or as a consequence of):	1'0
executed n end iel-transit	Sequentially list conditions, Due to	(or as a consequence of):	
68760, fliceta be executed g physicien end as the buriel-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events Due to		
0	resulting in death) Last	(or as a consequence of):	
death certi	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?
d by the setache	Congestive Heart	Failure	1 Yes 2 No 3 Probably Unknown
requir	Hypertension		24a. Was an autopsy performed?  24b. Were autopsy findings evailable prior to completion of ceuse of death?
The law cate has	Adenocarcinoma	of the Prostrate	1XYes 2 No 1 Yes 20 No
Of Vital Physician: The this certificate ral director, pag		Other	eth (Check only one)
2 00	To the section 21	□ ER/Outpatient 3 □ DOA □ Critical 4 □ Nursing F  28b. Time ot linjury at Work?	Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred
Division o Hospital or Attending Ph 24 hours after deeth. Eneral Director: After th wey filled in by the funeral	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be	28f. Location (Street and Number or Rural Route Number,	
Div	4 Homicide determined 256. Practs of Injury 2 Au building, etc. (Special Control of the Control	home, farm, street, fectory, office city)	City or Town, Stefe)
DIVISION To the Hospital or Attent within 24 hours after deet to the Eneral Director: corross wy filled in by the		nowledge, death occurred at the time, date and place nation and/or investigation, in my opinion, death occurred	e, and due to the cause(s) and manner as steted.  urred at the time, date and place, and due to the cause(s)
or the the		29c. License number	29d. Date signed (Month, Dey, Year)
M.	30. Name and address of purpoil who completed cause of death (If	M.D. RESOO	O October 12, 2000
0	Helen Z. Norwood, M.D.	, 2401 West Belved	ere Baltimore, MD 21215
State Registra	31. Date tiled (Month, Day, Year)  OCT 1 8 2000	Ange Kel	



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 3 2 9 2 |

		Certificate of														
Physicia	an	1. Decedent's Nem										2. Dete of De Month	eeth Day	Year	3. Time of Death	
/Medic	_		ine Gilm									Octobe		000	12:00 pm	
Examin	er	4e Facility Name (		give street and n						4b. City, To Lintl		ocation of Deal		y of Death Arur		
		5. Social Security N		6. Sex		(In yrs. last	hirthday	If Unde	r 1 Yeer							
Funeral Director		212-30-	4816	1□M 2(1)F		89	Yrs.	Months		Hours	Min.	8. Dete of Bi (Month, Di Aug. 9	y, Year) , 1911		pleca (Stete or Foreign intry) yland	
pu .		Usuet Residence o	10b. County			10c. City, T	own or Loc	ation							10d. Inside City Limits	
Maryle a-f sho	Director	MD		Arundel			apoli								X⊠ yes 2 □ No	
n th	9	10e. Street and Nu	mber					10f. Zij	Code				10g. Citizen of	What Cou	intry?	
P will		781 Eas	tern Po:	int Road	l				214	01			USA			
15-0020 n 72 hours after death with the Maryland "natural", or frems 28s or 28s-f show added Examiner must be notified at	Funeral	11. Maritel Stetus 1 Never Merr	ied 2□ Merrie	12. Was De Armed F d 1 Tes	Forces?	100		Ves Dece Yes, spe		lispenic Ori en, Mexicar Specify:		pecify Yes or No Rican, etc.)	14. Ra Ble Speci	can tndlen, , etc. White		
ours ours	by	3 🖾 Widowed	4 Divorced	Year or	Detes:			□ 103	2 23 110	Opeciny.			Speci	y.	W112 CC	
21215-0 3 within 72 ho jiene. r than matur the traces	steo	(Spe	15. Decedent's	Education grade completed	d)	1	6a. Deced	ent's Usu	el Occupation rk done during most of working				16b. Kind of I	3usiness/Ir	ndustry	
within then the Men	de la	Elementery/Seco			ollege (1-4or 5+)				ork done during most of working use retired)							
No se	d 2 should be filed within 72 ho th end Mental Hygiene. 7 is marked other than "naturi traumatic event, the Medical To Be Completed		1		Bookkeeper				er				Retail		thing	
DO SECTION			(First, Middle, L.										, Maiden Sume	me)		
Vent Went Went rice	10	Benjamin Galloway  19a. Informent's Neme/Retationship (Type, Print)					Josey					ohine Ca	adle			
Maryland 21215-0020 d 2 should be filed within 72 hours aft th end Mental Hygiene. The marked other than "natural", or treumstic event, the Medical Examples.		19a. Informent's N	1	19b. Meilin	g Addres	s (Street	and Number	er or Ru	rai Route Numb	er, City or Town	n, Stete, Zi	ip Code)				
CENL		Samuel '	on)	781 E	aste	rn P	oint	Road	l, Annap	polis, N	ID 21	401				
of Healt		20a. Method of Dis				20b. Plece	e of Dispos	sition (Ne	me of	ce)	1	Date 10 /3 7	20c. Location	- City or T	own, Stete	
Pages nent of the			☐ Cremetion : 5 ☐ Other (Spe	Removel from	m State		lcres				1	10/11 2000	Annapol	lic I	MD	
Baltimore, pemit. Pages 1 at Department of Hea Important: If Nem: any Injury or othe		21. Signalure of Fu		1112.01			22.	Name a	nd Addre	ss of Fecili	ty _			.15, 1	MD	
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		23a, Pert1, Enter I	the disease or o	omplications that	t caused t	the deeth. [							polis, N	ID 214	401 Approximete	
		shock or hee	ert tailure. List o	nly one ceuse on	eech line	B.	DO HOL BINE	1 (116 1110)	ao or ayn	ng, such es	Cardiac	or respiratory	311031,		Intervat Between Onset and Deeth	
Physician /Medical		Immediate Cause	(Final		0	,	-	7)							1 ,)	
Examiner		Immediate Cause disease or condition resulting in deeth)	on	a	K	Roma	Ta	1/NL	6					1	Inonth	
	-				0	Due to (or es	a consequ	uenca of)	1		0	•		1		
bet insti	를			b			nov			45	1)	seas	sease			
5x 68760, certificate be executed dring physician and use as the burial-transit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nditions, nmediate		D	Due to (or as	a consequ	uence of)								
68760, ficate be ex physician		Cause (Diseese or	erlying injury	C												
Sphys ett	edicai	that initiated event resulting in death)	5		D	ue to (or es	e consequ	ience of):								
Ocertifis ding	Me			d												
death o	lan	TELLIN														
. 5 0 0	Physician	Pert II. Other signi	ficant condition	s contributing to	death but	t not resultin	g in the un	derlying	cause gi	ven in Part	1.	23b. Did	tobacco use c	ontribute	to the cause of death?	
P.O. that the ed by the detached	P											1	Yee 2 No	3 Pre	obably 4 Unknown	
S the second	by										_			1		
Records,	Completed												s en eutopsy ormed?	6	Vere autopsy findings veilable prior to	
Pecce lew rate be ge 2 sh	ple				-									0	ompletion of cause of death?	
The It	ОШО											10	Yes 20 No	1	☐Yes 2☑No	
Vital   siclan: The certificate	0	25. Was case refer	red to medicat	T						26. Place	of Dea	th (Check only	one)		Gl l	
	0	axaminer? 1 ☐ Yes 2 ☑	No	Hospitel:	Inpatien	t 2DER	/Outpatien	3 D	OA Otl	nor:				ther (Spec	Chesapeake	
Phys or this	L i	27. Manner of Deal		28a. Det	e of Injury	/ 28	b. Time of		28c. Inju Wo				how injury occi		House	
On ding th. : After s fune	5	1) Neturel 2 Accident	5 Pending investige		onth, Dey	rear)	tnjury	М		Yes 2	No					
Division  or Attending siter death. Director: After d in by the fune	fice	3 ☐ Suicide	6 Could no	ed   400. Piec	ca of tnjur	ry - At home	, ferm, stre	et, factor	y, office					nber or Ru	rel Route Number,	
Divi	Certification:	4 Homicide	Octomi	buil	lding, etc.	(Specify)						City or To	wn, State)			
To the Hospital within 24 hours a	edicai C	29a. Certifier (Check only	Certifying	Physician: To the	basis of e	examination	dge, deeth and/or inv	occurred	at the ti	me, date an	d placa	, end due to the	cause(s) end r	nenner as	stated. to the cause(s)	
To the within 2 to the comple	1 N	one)	3	and ma	knner stati	ed.	1	- 00		an accordance	-		and Data sine	and /Adamsh	Onic Vond	
P#48 /	-	29b. Signeture end	Mile of certifier	1/4	1/	207	/	29	C. Licens	se number	1	٠, ا	29d. Date sign	ea (Month	) / Cay, rear)	
11		1/1	und	///	11	1			U	5/5	5	)	Octo	ber	11,2000	
101		30_Neme end add	ess of person w	ho completed car	use of de	eth (Item 23	le) (Type, F	Print)		11.1		11	-	,	12111	
1.0		Kussel	1000	becan Do	0-	1600	5-	(50	57	Highn	197	10/er	Burn	19,16	1. 61061	
Sta		31. Dete fited (Mon	th, Day, Year)	T 1 9 200	Registrar	s Signature	· ·	1	1	4	1,	, -, -				
Registra	ar		UL	1 1 0 20	UP.	100		1		200a	Ka					



State of Maryland / Department of Health and  Certificate of Death	Mental Hygiene	nn	32922
Certificate of Death	Reg. No.		02326
	2. Date of Death	0	3. Time of Death

	Physician	1. Decedent's Name (First, Middle, L	ast)	2. Date of D	eath		3. Time of Death					
	Physician	VERNON Har	FIS						OCTO	JOE Dey +	2006	400 Am
	/Medical	4e Facility Neme (If not institution, g		ier)		100		4b. City, Town, o			y of Death	
	Examiner	BON SECOURS H							TIMORE		110	
	Emand	5. Social Security Number 6.	Sex 7.	Age (fn yrs. le	st birthday)	If Under	1 Year	If Under 24 Hr		irth	9. Birthpli	aca (State or Foreign
	Funeral Director	213-20-8614	1 M 2□ F	74	Yrs.	Months	Days	Hours Min		, 1926	Count	aca (State or Foreign ry) UTIK
		Usuel Residence of Decedent		- / -					Apr Z	, 1920		
	Manyland H ahow	10a. State 10b. County MD		10c. City,	Town or Lo Bal	cation timor	e				10	od. Inside City Limits 1  Yes 2  No
	or deeth with the Manylar frame 23a or 28a-1 shown the mention at the mortised at the mercal Director.	10e. Street and Number 1217 W. Fayette	e Street			10f. Zip (		1217		10g. Citizen of	Citizen of What Country? USA	
020	n 72 hours efter deeth with the Manyle "natural", or flems 23a or 28s-f sho has all Evanturer must be notified at leted by Funeral Director	11. Meritel Status unk  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decede Armed Force	es? unk □No		Vas Decede Yes, speci	_	Hispanic Origin? ( ean, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	o- 14. Ra Bla Speci	in Indian, itc.	
0	2 ho	15. Decedent's 8	Education		16a. Deced	lent's Usual	Occup	pation	unk	16b. Kind of E	Business/Ind	ustry unk
21215-0020	ed within 72 ho ygiene. or then "naturi it, the Medical Completed	(Specify only highest g Elementary/Secondary (0-12) unk	College (1-4 unk	or 5+)	(Give life. L	NOT use	c done e retire	during most of w	orking			
	imore, Maryland Peges 1 end 2 should be file nent of Health and Mental Hys ant: If fem 27 Is marked othe ury or other traumatic evant, TO BE C	17. Father's Neme (First, Middle, Las	unk unk					18. Mother's N	eme (First, Middl	e, Maiden Sume	me) un	k
ary		19a. tnforment's Name/Relationship	rend Number or I	Rural Route Num	ber, City or Town	, Stete, Zip	Code)					
		Bon Secours Hospital 2000 W. Baltimore Street Baltimo										21223
more,		Bon Secours Hospital 2000 W. Baltimore Street Baltimore, MD  20a. Method of Disposition  1 Burial 2 Gremation 3 Removal from State  4 Donation 5 Mother (Specify) in State										
Balti	permit. Departri	21. Signature of pulsar size bio	enswade, Di	irector	1	State Baltin		atomy Bo	ard 655	W. Bal	timore	Street
1	Physician /Medical Examiner	23a Ph.1. Enter the disease, or continued, or heart failure. List online limited in the continued in the con	y one cause on eac	ontrol		Dial						Interval Between Onset and Deeth
Box 68760,	The law requires that the death certificate be executed are has been signed by the attending physicien end page 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner											
P.O. E	ires that the death signed by the atte d be detached for d by Physicia	Part II. Other significant conditions  Dehude		h but not resul	Iting in the u	nderlying ca	use gi	ven in Part I.		tobacco uss c		the cause of death
Vital Records, I	v requires that been signed should be de	Derigui	24e. We	s en eutopsy formed?	con	re autopsy findings illable prior to appletion of cause						
al Rec									10	Yes 2 No		leath?
/its	certificate rector, par	25. Was case referred to medicat examiner?	Managhal 6						eeth (Check only	one)		
=	Physic call direction To To	1 ☐ Yes 2 No	Hospital: Inp		R/Outpatier		^		Home 5□Re			)
Division of	ng the room	27. Menner of Death  1 Naturat 5 □ Pending 2 □ Accident investigati	28a. Date of (Month,	Injury Dey Year)	28b. Time of Injury	M 28	Bc. Inju Wo 1	ny at ork? ]Yes 2 □ No	28d. Describe	how injury occu	ırred	
Divis	lal or Attending P rs after death. at Director: After t led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	A 286. Piece of	Injury - At hor , etc. (Specify)	me, farm, str	eet, fectory,	, office		28f. Location City or T	(Street end Num own, Stete)	nber or Rura	Route Number,
	To the Hospital or Attendition 24 hours after death. To the Funeral Director: A completely filled in by the tachment of the form of the fo	29a. Certifier Check only 2 Medicat Exa	Physician: To the be aminer: On the basi and manner	is of examination	rledge, deeth on and/or inv	occurred a restigetion,	it the ti	ime, date end ple opinion, death oc	ce, end due to th curred at the time	e cause(s) and n a, date and place	nenner as sto , and due to	eted. the ceuse(s)
	within To the comp	29b. Signature end title of certifier	0			29c.	Licen	se number		29d. Date sign	ed (Month, I	Day, Year)

29b. Signature end title of certifier

29c. License number 7203 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
TURM CL AMB n.O BUN SECOUS

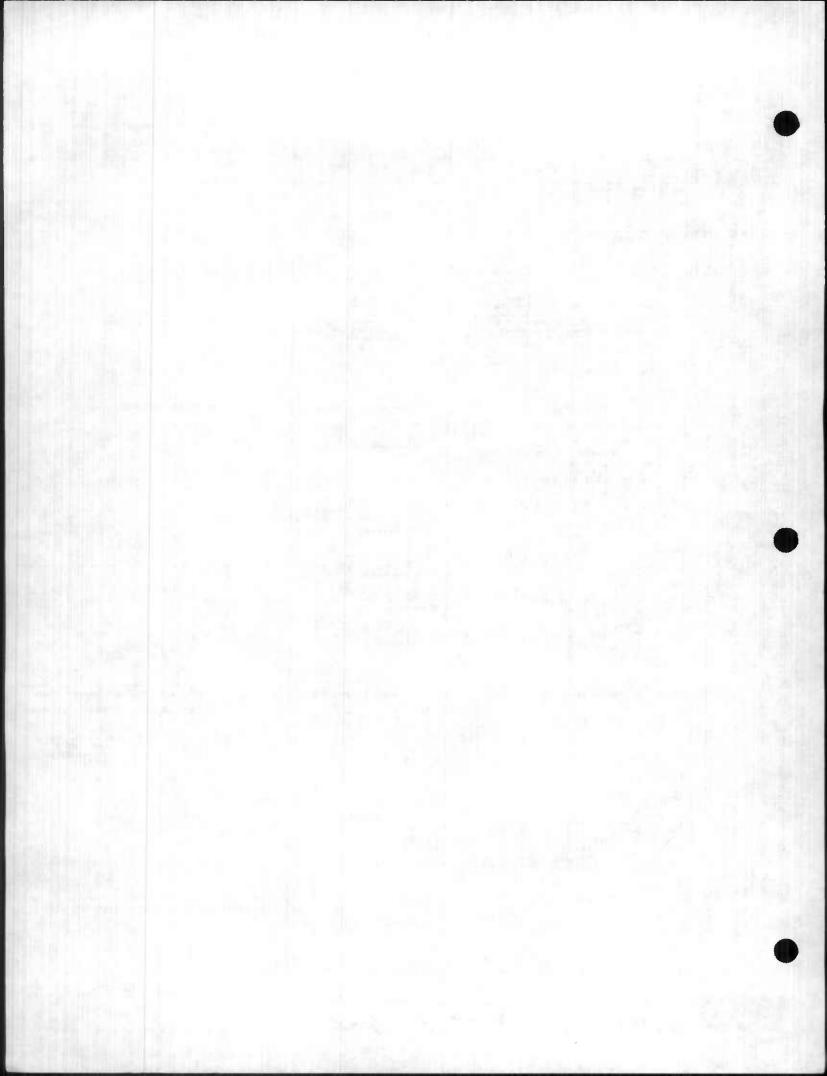
Baltinone Md

State Registrar

1.8 2000

31. Date filed (Month, Day, Year)





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HOEN 7:40 AM TERRANCE LEONARD OCT 16,2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner CTR. - G.B.M.C. TOWSON GILCHRIST HOSPICE BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 12M 2DF Months Days JULY 13,1954 Director 215-54-4905 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or Nerna 23a or 28a-f ahow 1 ☐ Yes 2 ☑ No Funeral Director MD HARFORD JOPPA 10e. Street and Number 10f. Zip Code 10c Citizen of What Country? Pace - American Indian, Black, White, etc. 21085 1011 DONNAINOOD DRIVE 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married py Specify 3 ☐ Widowed 4 ☐ Divorced netural WHITE Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) + 4 12 COMPUTER PROGRAMMER QUADRAMED CORP other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk Department of Health and Mental th Important: if Nem 27 is marked oth any Injury or other traumatic even Pobsa. LEONARD 5. HOEN POROTITY JEAN ELDREDGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) TERRIE LYNN COTTRILL HOEN, SPOUSE 1011 DONNA WOOD DR. JOPPA, MD. 21085 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Dete cemetery, crematory or other place)
EVANS FUNERAL CHAPEL 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State OCT. 17. 4 ☐ Donation 5 ☐ Other (Specify) FOREST HILL, MD BEL AIR-P.A. 2000 21. Signature of Funeral Service License 22. Name and Address of Facility EVANS FUNERAL CHAPEL 8800 HARFORD RD. PARKVILLE, MO. 21234 in caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Enter the **Physician** /Medical tmmediate Cause (Final o- rectal concer 4 ye Avs disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t 23b. Did tobacco use contributs to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 1 ☐ Yes 2 € No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) + OSPIC 10 1 Yes 2 No 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred spital or Attending Pl nours after death. neral Director: After the filled in by the funera 1 Naturat 5 Pending Injury 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital cantiling 24 hours all To the Funeral Discompletely filled in Medical 29a. Certifier 1🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of

State
Registrar

**DHMH 16 Rev 6/95** 

B

24dper 16,2000

Maryland 21215-0020

Box 68760

of Vital Records.

Division

tate 31. Date filed (Month, Dey, Year) CT 1 8 2

30. Name and address of person who completed

12118

32. Registrar's Signature

Gome

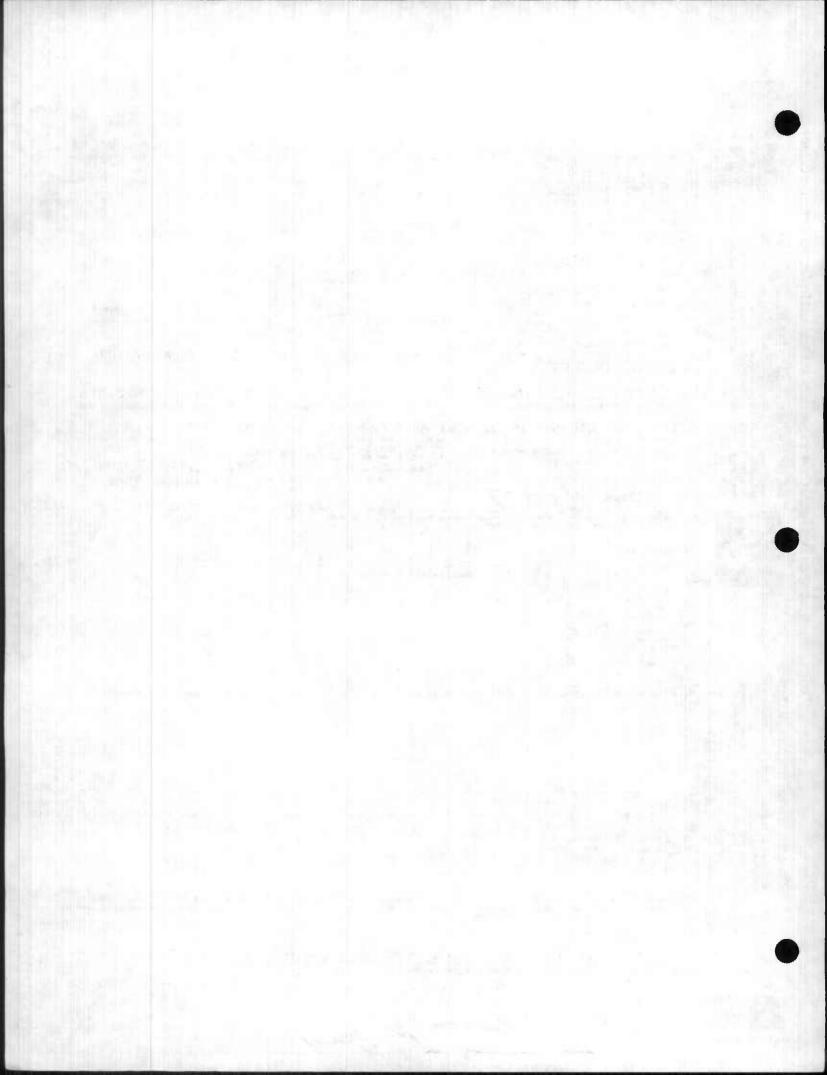
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les St. Balto. md 2120x

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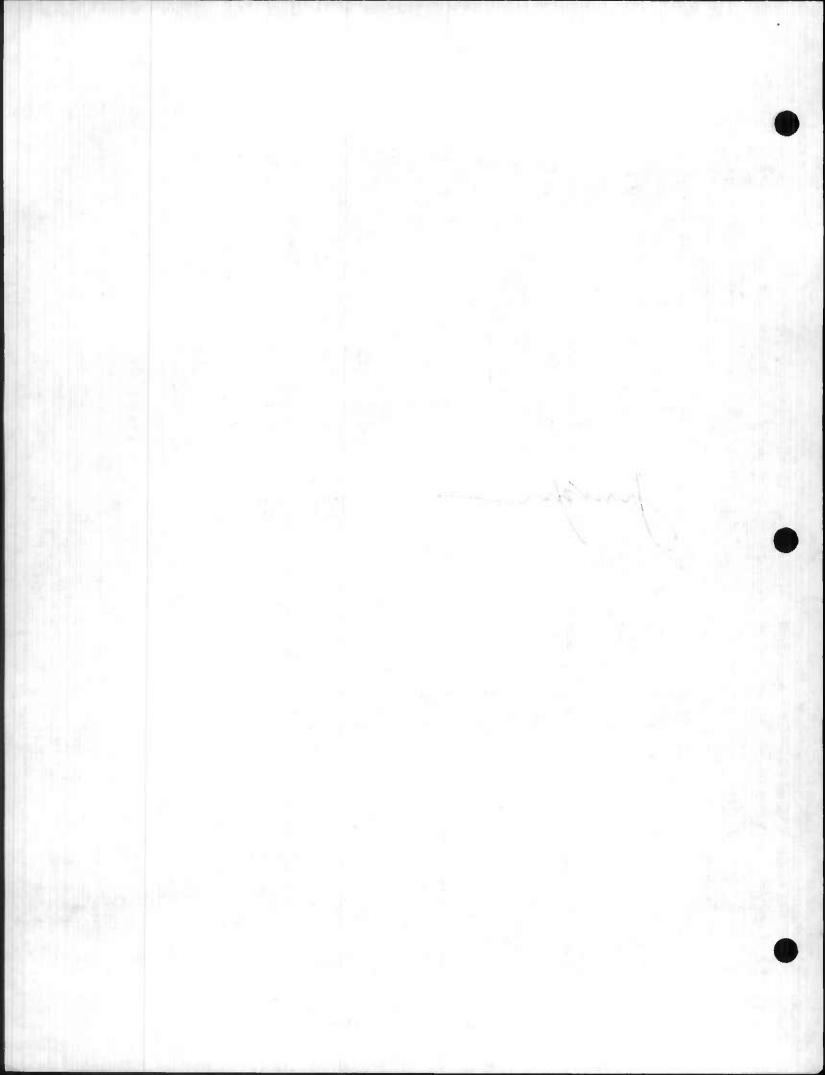
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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32924

			Cei	rtificate of	Death		Reg. No.		hape .	
	1. Decedent's Name (First, Middle, L.	ast)	1000			2. Dete of De	eth	3. Time o	of Death	
Physician	Burton	Co Hono				Month ()-4	16 2	Yeer 12:5	Oppy	
/Medical Examiner	4e Fecility Name (If not institution, gi	ve street end number)			4b. City, Town,	or Location of Deet	1		0	
LAdimirei	Howard Con	1 Ga . 1	16		Colin	1	House	. 0		
Funeral	7 1 M M M M M	Sex 7. Age (In yrs.	last birthdey)	If Under 1 Year			th	9. Birthplace (State	or Foreig	
Director	215-24-8819	100M 2□F 73	Yrs.	Months Days	Hours M		7, 1927	Maryland		
0	Usual Residence of Decedent									
how I	10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside C		
natural, or items 23s or 28s-f show dies Examiner must be noured at eted by Funeral Director	MD Anne Ar	runde1 0d	lenton					1 U Yes	s 2 🕅 N	
"natural", or frame 23a or 28a-f ahow edical Examiner must be notified at letted by Funeral Director	10e. Street and Number			10f. Zip Code		2	10g. Citizan of V	/hat Country?		
238	1247 Breitwert A	venue		211	13		USA			
	11. Manital Stetus	12. Wes Decedent Ever in L Armed Forces?	I,S. 13.	Wes Decedent of	Hispanic Origin? en, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Raci	e - Americen Indian, k, White, etc.		
A T		Armed Forces?  **Exyes 2 No  # Yes, Give		1□ Yes 2XXNo			Specify	2.27		
Exam	3 Widowed 4 Divorced	If Yes, Give Yeer or Dates: WWII					Openny			
ygiena. Ner than "natura it, the tendical Completed	15. Decedant's E (Specify only highest gi		(Give	dent's Usual Occu kind of work done	during most of v	vorking	16b. Kind of Bu	isiness/Industry		
than the	Elemantary/Secondary (0-12)	Collega (1-4or 5+)	life.	DO NOT use ratire	ed)					
other the vant, tre	10		HVAC	Enginee	,		1	Refrigerat	lon	
arked oth atic evan	17. Father's Name (First, Middle, Las	0				lame (First, Middle		e)		
marked matic e	Burton Hood					ces Gottl			9	
9 10 3	19a. informant's Name/Relationship					Rural Routa Numb				
item 27 other ti	Peggy Hood (Wife				rt Avenu	ie, Odent				
5 5 5	20a. Method of Disposition  1 X Burial 2 Cremation 3		cemetery, cre	osition (Neme of metory or other ple	ece)	Date 10/19		City or Town, State		
Department of I Important: if its any injury or o poce.	4 □ Donetion 5 □ Other (Spec		en Hav	en Cemet	ery	2000	Glen Bu	rnie, MD		
Importar any inju	21. Signature of Funerel Sarvice Lice	osee	22	2. Name and Addr Hardest	ess of Fecility	al Home,	P.A.			
2 5 5 8	Jan 19	n	-		_	ue, Anna		D 21401		
	23a. Part1. Inter the disease, or cor shock or heart failure. Vistont	nplications that caused the dee	th. Do not ent	ter the mode of dy	ing, such es card	liac or respiretory a	errest,	Approxima Intervet Be	ate	
nysician	Shock of heart failure. Urstoni	one cause on each line.						Onset and	Death	
Medical	Immediate Ceusa (Finel diseese or condition	71 200000	1	P				00	,	
aminer	resulting in death)	a. NOSOCO	or as a conse		العن	4		1/000	45	
ةِ السو		202 10 (	01 40 4 001100	quanto 01).				C		
is the burial-transit	Sequentially list conditions	b	or as e consec	quence of):						
EX.	Sequentially list conditions, if any, leeding to immediate causa. Entar Undarlying Cause (Disease or injury that initiated events									
ysicie se bu	Cause (Disease or injury that initiated events	C. Due to (	or es e consec	quence of):						
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for use	1700	d								
od for	Pert ii. Other eignificant conditions	contributing to death but not re-	sulting in the u	inderlying ceuse a	iven in Pert I.	23b. Dld	tobacco uae cor	ntribute to the cause	of death	
igned by the attandir be detached for use by Physician/R				^		10	Yee 2 No	3 Probably 4	Unkno	
e del	Chronic Renol F	orlure, Pleural			zagan sa	del				
sta has been signed by the attandin page 2 should be detached for use Completed by Physician/N		Failure, Periph			0		s en eutopsy	24b. Were eutopsy evailable prior	y findings	
cartificata has been si irector, page 2 should I	Congestive Heart	Failure, Periph	re-ol V	loseder	Liseuse	pen	ormed?	completion of of death?	cause	
a has			,	0		10	Yes 2 No	1 ☐ Yes 2	300	
s cartificata he director, page To Be Com	25. Was case refarred to medical	Obstactic Pl	more	- Wise	Esp Seps	Death (Check only		10 165 20	3 140	
rector Be	axaminer?	Hospital:	7500		lhor			as (Canaiba)		
90	1 Yas 2 No	28e. Date of Injury	28b. Time o	HI SLI DOA	4 LI NUISIN	g Homa 5 Res	how injury occur			
La hours after death.  Funeral Director: After thingshifted in by the funeral strength of the funeral strength of the funeral certification:	1 Netural 5 Pending	(Month, Day Year)	injury	W	ork? ☐Yes 2☐No		, , ,			
ctor: A y tha f	3 ☐ Suicide 6 ☐ Could not	De Dian of lains Ath	ome farm st			28f. Location	(Street and Numb	per or Rural Route Nu	mber.	
Direction of the property of t	4 Homicide determined	building, etc. (Speci		root, ractory, critical	150	City or To	wn, State)			
hours ly filled Cai C	29a. Certifiar 1 Certifying P	hyeldian: To the heet of my kn	oudedes dest	h occurred at the t	ime date and ni	nce and due to the	causa(s) and ma	nnar as stated		
Funeral parishy filled adical C							dua to tha causa(s) and mannar as stated. at tha time, data end place, and due to the causa(s)			
1	29b. Signeture and title of certifier	and manner stated.		29c. Licer	se number		29d. Date signe	d (Month, Day, Year)		
Je	-2-(	). /		1	1.		^ /	,		
1	10	m	Ulm	1	4612	0	Cct, 1	6, 200	0	
110	30. Name end address of person who	completed cause of death (ite	m 23a) (Type,	Print)						
U	1- Dellan	10724 Little	Pot	vyent.	Pkery,	Colch	bee, 6	70 710	144	
State	31. Date filed (Month, Dey, Year)	32. Registrer's Sign	ature	6 0	0-					
Registrar	'AOT 1 9	2000 hear	per /	0 000	and a					
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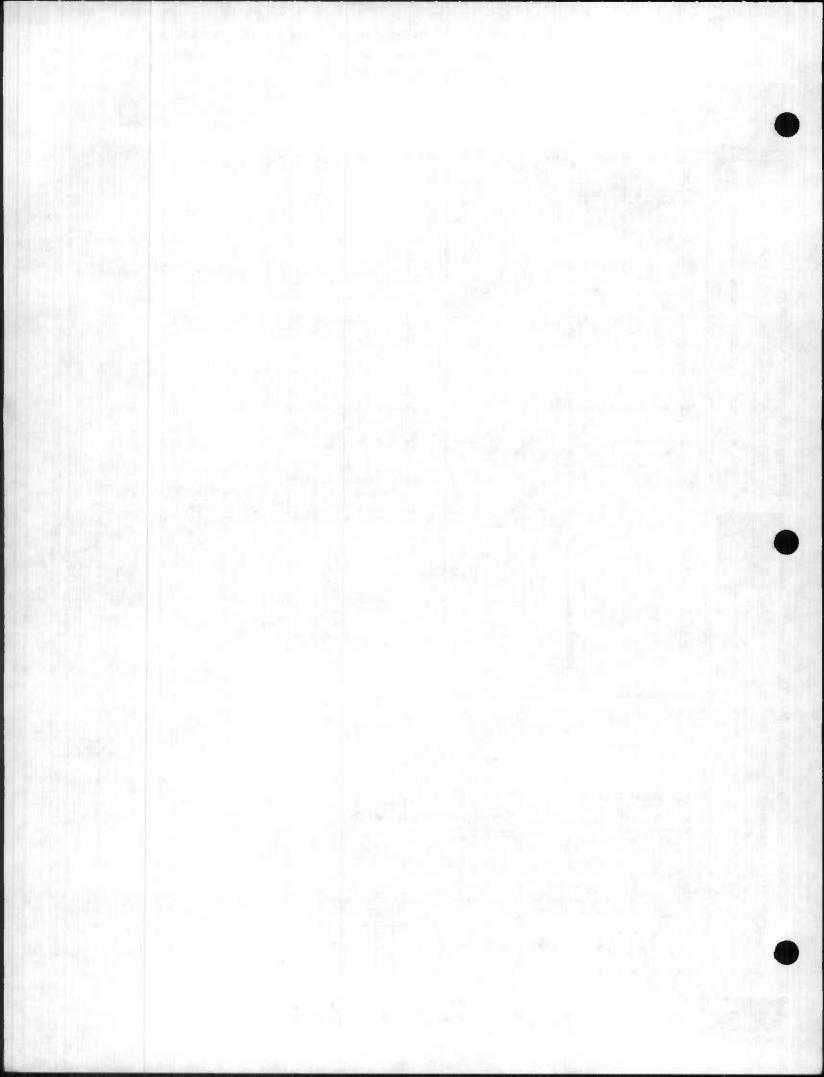
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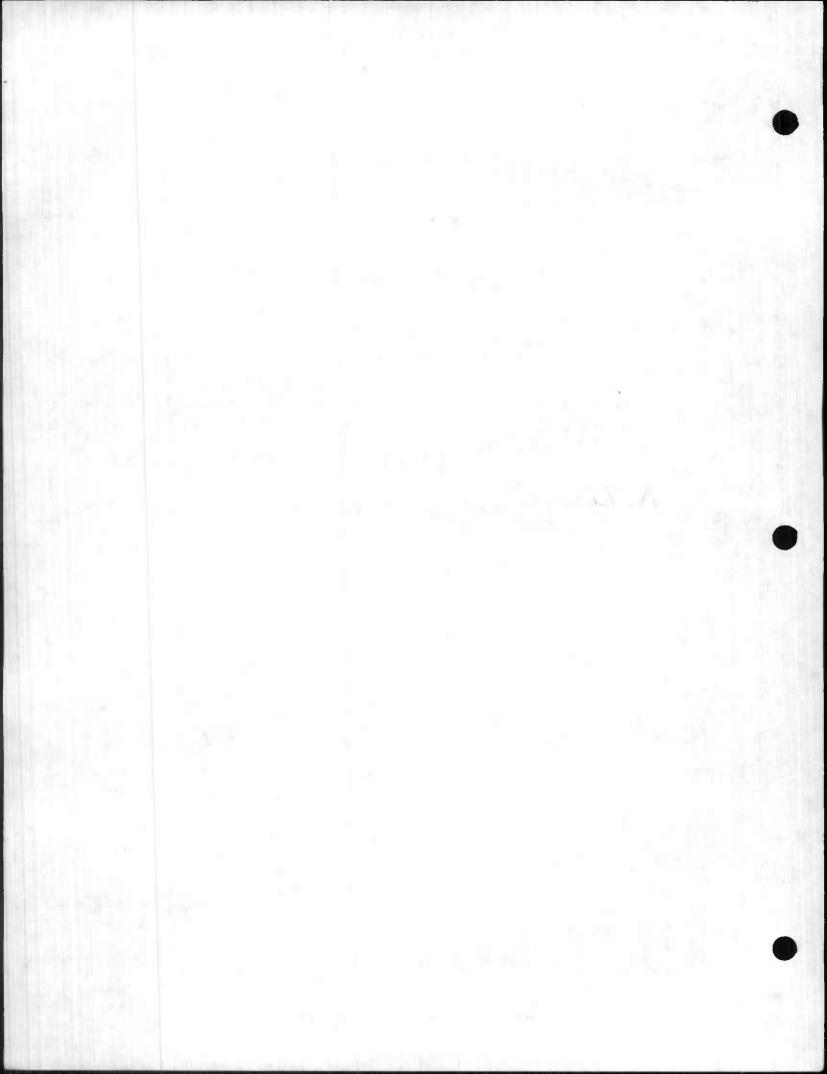
State of Maryland / Department of Health and Mental Hygiene

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	1. Decedent'e Name (First, Middle, Last)  Certificate of Death  2. Date of Death												
Dharatatan	1. Decedent'e Name (First, Middle, Last)									eath Day	V	er 3	3. Time of Death
Physician /Medical	Patricia M. Ha	rvey							OCT.	16, 2	000		1:50P.M.
Examiner	4e Fecility Name (If not institution,	give street end number	or)			4	b. City, To	wn, or Lo	cation of Des	th 4c. 0	County of I	Death	
of.	85 Will-O-Broo	k Dr.					Pasa	dena		Anı	ne Ar	unde.	1
Funeral	5. Social Security Number	6. Sex 7. /	Age (In yrs. last b	irthday)	If Under		If Under		8. Dete of B	irth lay, Year)	9.	Birthplace	e (Stete or Foreign
Director	216-40-2440	1□M 2 <b>S</b> F	62	Yrs.	Months	Deys	Hours	Min.	3-3-1	938	Ма	ryla	nd
10	Usual Residence of Decedent												
M M	10a, Stete 10b, County		10c. City, Tov	wn or Loc	cation							10d.	Inside City Limits
the field rot	MD Anne	Arundel	Pasad	ena									1 ☐ Yes 2 No
or 25e-f s be notified Director	10e. Street and Number				10f. Zip	Code			100	10g. Citiz	en of Wha	t Country	?
The or	85 Will-O-Broo	k Dr			2	1122					CA		
1020  Jura shar death with the Maryla  Wil, or farms 22a or 28a-f sho  Examiner must be notified at  by Funeral Director	11. Meritel Stefus	12. Wes Deceder	of Ever in U.S.	13. V	Ves Dece	dent of H	lispenic Or	igin? (Spi	ecify Yes or N		S.A.	Americen	Indian,
Fur inter	1 Never Merried 2 Marri	Armed Force					en, Mexice	n, Puerto	Ricen, etc.)			White, etc.	
5-0020 72 hours after natural, or to dical Examina eted by Fu	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates		1 ☐ Yes 2 No Specify:						3	Specify: W	hite	
of an an be	15. Decedent	s Education	166	e. Deced	ent's Usu	el Occup	ation				d of Busin		
Plet and Plet	(Specify only highes	1	-5.	(Give I	kind of wo	rk done i se retired	during mos d)	st of work	ing:				
1 21215-0020 led within 72 hours at hydrens, her than 'natural', or nt, the Medical Exam Completed by F	Elementery/Secondery (0-12)	College (1-40	Ir 5+)	H	ousev	vife				Own	Home		
	17. Father's Neme (First, Middle, L	.ast)		0.35	3.1		18. Moth	er's Neme	(First, Middl	e, Maiden S	Sumeme)	- 1	M. L. C.
Alamad de Barrella	Alvin W. Robe	rtson					Mar	ie Co	nrad				
The state of the s	19a. Informent's Neme/Reletionsh		19	b. Mailin	o Address	(Street			al Route Num	ber, City or	Town, Ste	te, Zip Co	ode)
Maryland nd 2 should be file sith and Mental Hy 27 is marked other r traumatic event To Be (	Jerome E. Harv								sadena				
0 -116	20a. Method of Disposition	cy (massand	20h. Place	of Dispos	sition (Ner	ne of		· La	Dete	-	ation - Cit		. State
Pages 1 a rent of Hea ray or othe	1 Burial 2 Cremetion		(6)		netory or o			1	6.90				
	4 Donetion 5 Other (Sp		Glen						-19-00	Gler	n Bur	nie,	MD.
Baltim permit. Pa Departmen important: any injury ance.	21. Signature of Funerel Service L	icensee		22.			ss of Fecil		Funera	al Hon	ne P.	Α.	
	John 7	4 belline			3204	1 Moi	untai	n Rd	Pasa	dena.			2
	23e. Pert1. Filter the disease, or shock, or heart feilure. List of	complications that caus	ed the deeth. Do	not ente	er the mod	le of dyin	ng, such es	cerdiac	or respiretory	arrest,		Ar	oproximate tervel Between
Physician												O	nset end Death
/Medical	Immediate Cause (Finel disease or condition	u	mg	ca	nc	er						(	year
Examiner	resulting in deeth)	a	Due to (or es e	consequ	uence of):							1	0
ē = g													
X 68760, partificate be executed ding physician and se as the burial-transit	Sequentielly list conditions,	Б	Due to (or as e	consequ	uence of):		17.17						
O, exe	Sequentielly list conditions, if any, leeding to immediate cause. Enfer Underlying												
68760, fficate be experience the burial est the burial edical E	Cause (Diseese or injury that initiated events	С.	Due to (or as a	consequ	uence of):							1	
es the set of the set	resulting in death) Last  Due to (or as a consequence of):												
	d												
Is, P.O. Bo es that the death of igned by the atten be detached for u by Physician	Part II. Other significant condition	as contributing to death	but not resulting	in the un	nderlying o	euse niv	en in Pert	1.	23b. Di	d tobacco u	es contri	buta to th	e causs of death?
P.O. at the de dached etached						oudo g				Yss 2		/	oly 4 Unknown
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(ecords, P.O.) law requires that the as been signed by the 2 should be detach appleted by Phys										s an autop:	sy 2		eutopsy findings
v require been si should									per	formed?			ble prior to letion of ceuse
The law requires the law requires the law requires the page 2 should be completed by										144			/
A 4 8 0											No	1 🗆 Y	es 21 No
Division of Vital or Attending Physician: T effer death. Director: After this certificat in by the funeral director, pertification: To Be C.	25. Wes case referred to medicel exeminer?	Hospitel:				Oth	or		h (Check only				
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Ing P unen unen unen unen unen unen unen un	27. Menner of Death  1 Neturel 5 Pending		Dey Year) 280.	Time of Injury		28c. fnjur Wor			28d. Describ	B now injury	occurred		
Attending Parton: Attending For death. Sector: After by the funer iffication:	2 Accident investig	ot be			М		Yes 2	No		100			
Oivi or An offerd Direct In by	4 Homicide determi	and ZBB. PIRCR OT	Injury - At home, I etc. <i>(Specify)</i>	ferm, stre	eet, fector	y, office				(Street and own, Stete)		or Rurel R	loute Number,
25 2 2 O												4.50	
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2238/8	one)	end menner											
M M	29b. Signeture end title of certifier	uangen	. D		29	c. Licens	e number			29d. Date	signed (/	Month, De	y, Year)
1	mar	D.			0	39.	505		yct	sse	2 1.	7,2000	
20	30. Neme and address of person v	who completed ceuse o			Print)			100	11		1/5	1	MD
alo	Yudhish M	1600 C	na	in	the	y #	602	, 61	m 15	un	42	7,2000 MD 21061	
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Registrar	OCT	L 8 2000 >	Benev		D	100	acks						

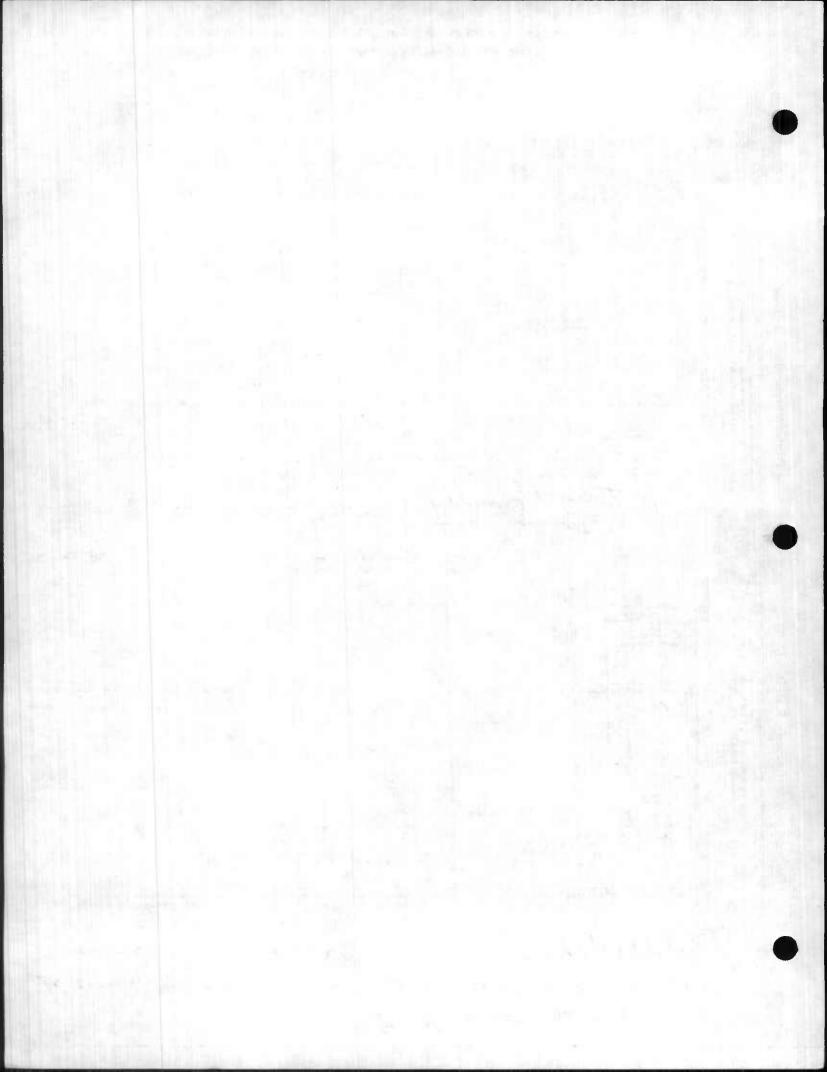


	812-510 amend item	23a,ptII, 23b., 27 pe	State of Marylar	100				giene	0 3	292	6		
	andra roan	1. Decedent's Name (First, Middle, Las		yroc yro.			2. Dete of Dea	ith	494	3. Time of	Death		
	Physician	James Russell Hei	m				Month OCTOBE	Dey R 11. 2	Year 1000	1657	PM		
	/Medical Examiner	4e Facility Name (If not institution, give				4b. City, Town,	or Location of Death			1001	***		
		ST. AGNES HOSP.	ITAL			BALTIM	ORE CITY						
	Funeral	Social Security Number     6. Security Number			If Under 1 Year Months Deys	If Under 24 H	in. 8. Dete of Birt (Month, De	, Year)	9. Birthp Coun	lece (State o	r Foreign		
ш	Director	165-34-0876	M 2□ F 56	Yrs.			Feb. 22,			ylvan			
	and	Usual Residence of Decedent  10a. Stete 10b. County	10c. C	ity, Town or Lo	cation			10d. Inside City Limits					
	faho or	MD Baltimor								1 ☐ Yes	30No		
	or 28e-f a	10e. Street end Number	C 1555	CA.	10f. Zip Code	<del></del>		10g. Citizen of	What Coun	try?			
	uth with the Marylan 23a or 28a-f ahow unt be not find at rai Director	150 Wiltshire Roa	a		21221								
	r terms 23	11. Merital Stetus	12. Wes Decedent Ever in U	J,S. 13. \	Was Decedent of I	lispanic Origin?	(Specify Yes or No-		ce - Americ				
Maryland 21215-0020	0 0	1 (2) Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Dates:	9-15-15-1	f Yes, specify Cub 1 ☐ Yes 2 🙀 No		erto Rican, etc.)						
0-0	72 hours natural, airal E.	15. Decedent's Ed		16a. Deced	dent's Usuet Occup	pation	undring	16b. Kind of B	usiness/Inc	dustry			
21	ed within 72 ho yglene. The train all it, the trained	(Specify only highest grade Elementery/Secondary (0-12)	Cotlege (1-4or 5+)	life. L	DO NOT use retire	d)	VOIKING						
21	od will	12		Parts	Clerk			Teltron		1timo	re Inc		
pu	TI S O	17. Fether's Neme (First, Middle, Last)				18. Mother's N	Neme (First, Middle,	Maiden Sumar	ne)				
yla		Ralph E. Heim		_		Mary J	ane Russe	11					
Mar	0 0 2 6	19e. Interment's Neme/Retetionship (7		19b. Meliir	ng Address (Street	end Number or	Rural Route Number	r, City or Town	, Stete, Zip	Code)			
	C = 0 +	Ralph E. Heim/Bro			Patapsco	Avenue,	Baltimor		21222				
Ore	00 _ 5	20e. Method of Disposition  12 Buriat 2 ☐ Cremetion 3 ☐		cemetery, crer	netory or other ple	ce)	Date	20c. Location	- City or To	wn, State			
tim	tment tant: h	4 □ Donation 5 □ Other (Specify		lly Hil			10/16/00	Balti	more,	MD			
Baltimore,	pemit. Pag Department Important: I any injury o	21. Signature of Funerel Service Licen	100	, 0		Funeral	Home Of Baltimor		21221				
68760,	death certificate be executed e attending physician and od for use as the burial-transit sician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	bDue to (	C CARDION for es e consequence or es e consequ	juence ot):	SEASE							
Box	at the death certificate by the attending pletached for use as the stack of the second place of the second	Pert It. Other significant conditions or	d	sulting in the u	nderlying cause gi	ven in Pert I.	23b. Did	obacco use co	ontribute to	the cause	of death?		
P.0	by the			•			10	Yes 2 No	3€ Pro	bably -	Sinknown		
	bed bed by	CIRRHOSIS			144		24e. Wes	en eutopsy med?	ev	ere autopsy i	to		
Records	has be law						-	/	of	mpletion of deeth?			
	delen: The certificate h rector, page	25. Wes case referred to medical				Of Pines of f	Dooth (Check only)		11	Pres 2□	NO		
Vital	Physicien: this certific ral director. TO Be (	everniner?	Hospitet: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatier	nt 3EXDOA Off	her:	Deeth (Check only of g Home 5 ☐ Resid		her /Snecil	5/1			
on of	eath. or: Atter this the funeral di	27. Manner of Deeth 1 ☑ Natural 5 ☐ Pending	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju Wo		28d. Describe			,,			
Division		2 Accident ##Vestigation 3 Sulcide 6 Could not be 4 Homicide determined		nome, term, str	reet, tectory, office		28t. Location ( City or Ton	t. Location (Street and Number or Rural Route Number, City or Town, State)					
	Hospi 24 hour Funer stely fill	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my kn hiner: On the basis of examin end menner steted.	owledge, deeth etion end/or in	n occurred et the ti vestigation, in my o	me, date and ple opinion, death o	ece, end due to the ccurred et the time,	cause(s) and m date and placa	enner as s , and due to	tated. the cause(s	3)		
	To the within To the comple	29b. Signature end title of certifier	tann	M.D	29c. Licen:	ME		29d. Date sign					
		30. Name and address of person who of	festaner			Street,	Baltimor	re, Mary	land	21201			
	State Registrar	31. Dete tiled (Month, Day, Yeal)	32. Registrer's Sign	neture	B. A.	rocks					2111		



State of Maryland / Department of Health and Mental Hygiene

			Certif	icate of	Death		Reg. No.	3	2921	
Physician	1. Decedent's Neme (First, Middle,		WOLLD DE			2. Date of De Month	bath Day	Year	3. Time of Death	
Physiciar /Medica		CHERYL L	HOWARI	)		OCT.	15 2	000	10:45pm	
Examine	4a Facility Name (If not institution, g			153	4b. City, Town,	or Location of Deet	h 4c. County	of Death		
	917 Punjab C		- f 4 t-24t-4-1   16	Under 1 Yeer	Esse			alti		
Funeral Director	5. Social Security Number 214–50–6135  Usual Residence of Decedent	4 TIM OFFICE		onths Days		Ain. 8. Date of Bi (Month, De June 29	n, Year) 9 1948		laca (State or Foreign try) rland	
Pag an	10a. State 10b. County	10c. 0	City, Town or Location	on				10	0d. Inside City Limits	
death with the Maryla me 23e or 28e-f shor r mat be notified at	MD Balt	imore	[1	Es	ssex		10g. Citizen of V	What Coun	1 ☐ Yes 2/€ No	
23s or sust be					21221		USA			
ors after alf, or the Examine	3 □ Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces?  1 ☐ Yes 2 ②No If Yes, Give Yeer or Dates:		Decedent of I		? (Specify Yes or No uerto Rican, etc.)	Blac	e - America ck, White, o	etc.	
ed within 72 ho ygiens. er than 'netur i, the Medical.	15. Decedent's (Specify only highest)	Education trade completed)	16a. Decedent (Give kind	's Usual Occu d of work done	petion during most of ed)	working	16b. Kind of B	usiness/Ind	lustry	
Par Par	Elementary/Secondary (0-12)	College (1-4or 5+)					Coolo	1 Con		
		n#1	Com	puter A	Assistan	IT Name (First, Middle			curity	
the state of	Ď .				TO. MIOLITET ST			10/		
d Mend	John J Baye  19a. Intormant's Name/Relationship		19h Mailing A	ddress (Stree	t and Number of	Maxine Rural Route Numb	Reeves	State Zin	Codel	
nd 2 a	Deborah Howard				ood Ave.		nore MA			
-364	20a. Method of Disposition		. Plece of Dispositio	on (Neme of		Date	20c. Location -			
L. Pages tment of tant: If he jury or o	1 Burial 2 Cremation 3 4 Donetion 5 Other (Spe	city) N	cemetery, cremeto fetro Crer	matory	Inc. 10	/18/2000	Balit	more	Md.	
Depart Depart Import any in	21. Signeture of Funeral Service Lic	Conneli	ly Co	OO MACE	Funera	al Home of	Md 212	21		
Physician /Medical Examiner	23a. Part 1. Enter the disease of shock, or heart tailure. List of limited the shock of the disease or condition	mplications that caused the dipone cause on each line.		re mode of ay	ng, such as car	diac or respiratory a	irrest,	1	Approximate interval Between Onset and Death	
	resulting in death)	Due to	(or es a consequen	nce ot):			11	1		
cate be executed physician end s the burial-transit		Due to (or as a consequenca of):								
E 2"		Due to	(or as a consequen	ce ot):						
atter for u						l ant mi				
t the by th		contributing to death but not re	esulting in the under	riying cause gi	ven in Pert I.		Yes 200		the cause of death? bebly 4 - Unknown	
aw requir						24a. Was	s en eutopsy ormed?	ava	ere autopsy tindings ailable prior to mpletion ot cause death?	
The law ate hes page 2						1 🗆	Yes 2 100	10	Yes 25No	
ysician: The second director, page					26. Place of	Death (Check only	one)	1		
2 00		Hospital: 1 Inpetient 2	☐ ER/Outpatient	3LI DOA		ng Home 5 Anes	idence 6 □Ott	ner (Specif	(ע	
Attending Ph r deeth. ector: After thi by the funeral		28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju Wo M 1	iry at ork? ]Yes 2∐No	28d. Describe	how injury occur	red		
A POP A	3 Suicide 6 Could not determine	28e. Place of Injury - At building, etc. (Spec	home, tarm, street, city)	tectory, office			(Street end Numl wn, Stete)	per or Rure	il Route Number,	
Hospi 24 hou Funer tely fill		Physician: To the best of my kraminer: On the basis of examinand manner stated.								
To the	29b. Signeture end title of certifier	M		29c. Licen	se number		29d. Date signe	d (Month,	Dey, Year)	
10	MILIMICA			De	+1490		10-1	7 - 7	2000	
194	30. Name and address of person wh	o completed cause of death (It		Fig. (	lan S.	me Dr	3.6			
State	31. Date tiled (Month, Day, Year)	32. Registrar's Sig	9103 nature	Vank	7 24	W DY	, your			
Registrar	AAT	4.	4	1	,					

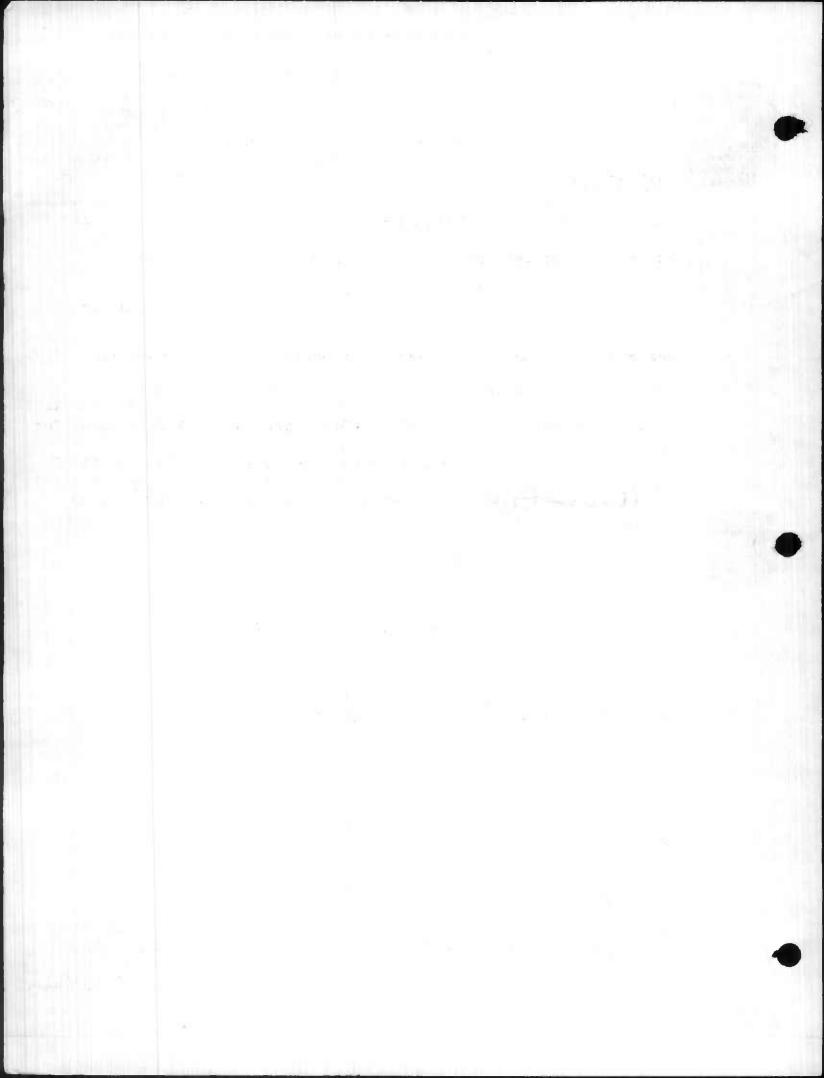


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month Vaar **Physician** OTIS JOHNSON 5:48au DC4060 16 2000 /Medical 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Hospital Jamantan Baltimore H Undar 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) 06-02-21 If Undar 1 Year Months Days 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** NOM 2□ F 246-40-5930 Director Usual Rasidanca of Dacedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner man be notified at Director YSYas 2□No MD NA Baltimore 10g. Citizan of What Country? 10e. Straat and Number 10f, Zip Coda 401 E. 25th Street Apt. 11A 21218 USA 2 should be filed within 72 hours after death very and Mental Hygiene.
Is marked other than "natural", or Items 23 12. Was Dacedant Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Married 2 Married 1 ☐ Yas 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Etementary/Secondary (0-12) Collega (1-4or 5+) Unknown Master Mechanic Automotive 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Smith Johnson Cora Lee 21218 19a. Informant's Name/Ralationship (Type, Pnint) 19b. Matting Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traun once. 401 E. 25th Street Apt.llA Baltimore, Alean Johnson 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 ₺ Burial 2 □ Cramation 3 □ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Spacity) Voshell Mem. Gardens 10-20-2000 Dundalk, MD 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part1. Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onsat and Death **Physician** /Medical Immadiata Causa (Final disaasa or condition rasulting in daath) Examiner Examiner attending physician and for use as the burial-transit Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Disaasa or Injury Infarct Muocardial Box 68760, Physician/Medicai that initiated avants rasulting in death) Last ed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? Renal signed by t Disease 1 Yes 2 No 3 Probably 4 Unknown p 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Sins Syndrome Completed 20 No 1 Yas 2 No Division of Vital 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) Minpatiant 2□ER/Outpatient 3□ DOA 70 funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: After t 1 Natural
2 Accident 5 Panding invastigation 1 ☐ Yas 2 ☐ No death. after death Director: / 6 Could not be datarminad 3 ☐ Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Spacify) 4 Homicida 24 hours a Funeral D 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar Medical To the Hosp within 24 hor To the Fune completely fi (Check only 29b. Signature and titip of ceptifier 29d. Data signed (Month, Day, Year) 29c. Licansa number P13453 MO 30. Nama and addrass of parson who complated causa of death (Itam 23a) (Type, Print) 1601 Loch Raven Bulevard, Baltimore GIANBZLIA 40NZA 20 31. Data filed (Month, Day, Year) 32. Registrar's Signatura Beneva Registrar

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 00 32929

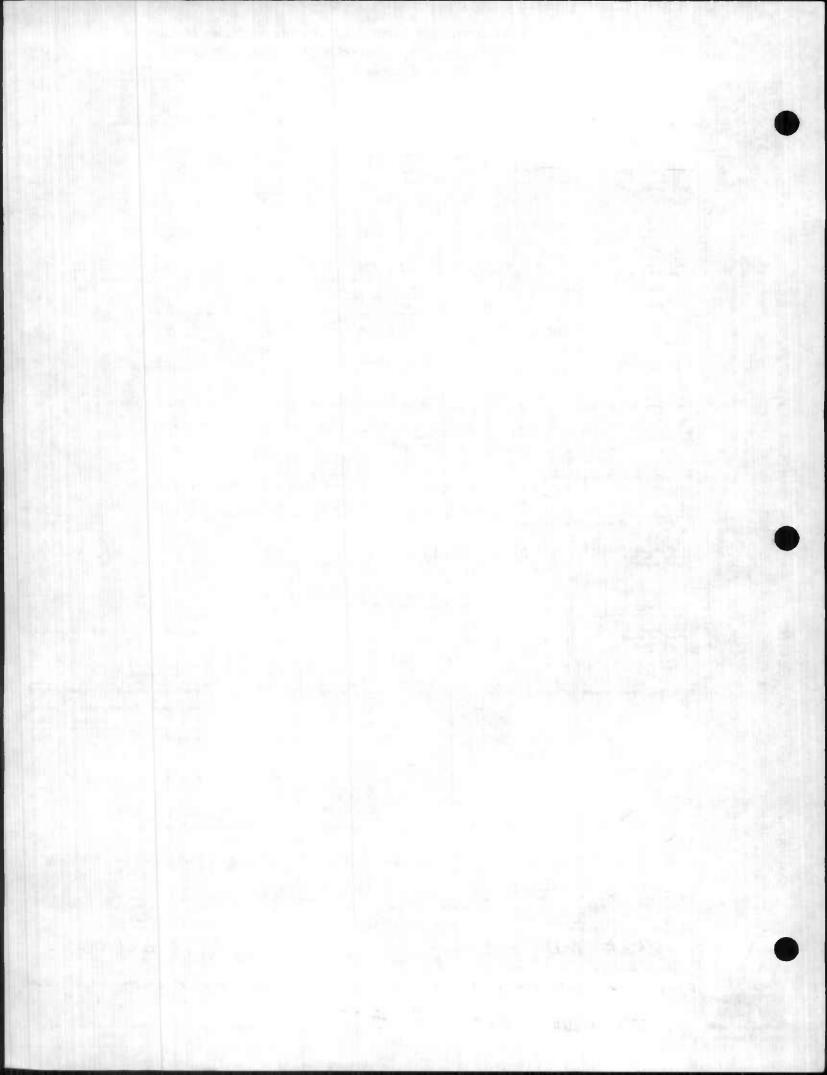
			C	ertificate o	f Death		Reg. No.				
	1. Decedent'a Name (First, Middle,	Last)		SECTION 1		2. Dete of De	ath Day	Yeer	3. Time of Death		
Physician /Medical	Luke F	. Johns	son			Octob	ER 8,0	2000	4111		
Examiner	4a Facility Neme (If not institution,	give street end number)			4b. City, Town, or L	ocation of Death					
	Mercy Hosp	ital			Baltimo	re					
Funeral		. Sex 7. Age (In	yrs. lest birthde	y) If Under 1 Ye		8. Dele of Birt (Month, Da	lh Year)	9. Birthp	lace (State or Foreign		
Director	217-20-5247	1X M 2□ F 75	Yrs.	Months Dey	ys Hours Min.	9/13/	25	Nels	SONCO, VA		
	Usuel Residence of Decedent										
No. of M	10a. State 10b. County	10	c. City, Town or	Location				1	0d. Inside City Limite		
to to	Md.		Balti	more					XXYes 2 No		
be notified Director	10e. Street and Number		20101	10f. Zip Code	Ð		10g. Citizen of	What Cour	itry?		
	2741 E. Pres	ton Street		212	019		USA				
ion mat ion mat Funeral	11. Maritel Stetus	12. Was Decedent Ever			T Ongin? (Sp	ecify Yes or No		ce - Americ	an Indian.		
F 8 F	1 Never Married 2 Married	Armed Forces?	11 0,0.	If Yes, specify C	uban, Mexican, Puerto	Rican, etc.)		ck, White,			
by B	3 ₩idowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Detes:		1 ☐ Yes 2 💆 N	lo Specify:		Specif	y: B1	ack		
D P	Λ		10- D-	-dW-111 O			10h Kind of B		disates		
n, the Medical I	15. Decedent's (Specify only highest)		/Gi	cedent's Usuai Occ ve kind of work don . DO NOT use ret	ne during most of worl	king	16b. Kind of B	usiness/inc	oustry		
E E	Elementary/Secondery (0-12)	College (1-4or 5+)					D 413				
	12		0	teel W	orker	(FT: 4 A 4: 4 N			Steel		
B S	17. Father's Neme (First, Middle, La				18. Mother's Nem	ie (First, Middle,	Maiden Sumei	ne)			
10	Walter Jol	nnson			Halli	e Jo	hnson				
	19a. Informent'a Name/Relationship		19b. Me	iling Address (Stre	eet and Number or Ru	ral Route Number	er, City or Town	, State, Zip	Code)		
2	Luke Johnson	Jr. Son	591	2 Highs	ate Dr.B	altimo	re Mar	vlan	d 21215		
-	20e. Method of Disposition		Ob. Place of Dis	position (Neme of	· ·	Date	20c. Location	- City or To	wn, Stale		
8	1 Buriel 2 □ Cremation 3 4 □ Donetion 5 □ Other (Spe	Removal from State			onal Pk	10/11/	00 T a	7	M.1		
4	21. Signature of Funeral Service Lic			22. Neme and Add		10/14/	оо дац	rel,	Ma.		
A SU	21. Signature V	10 01				Funoro	1 Con	D A			
	dond	Mr. Cite	rothers taw Plac	e, Bal	timore	Md	21217				
	23a. Pert1. Enter the disease, or co shock, or heart failure. List or	emplications that cause the	death. Do not e	enter the mode of o	dying, such as cardiac	or respiratory a	rrest,		Approximate Intervai Between		
ician									Onset and Death		
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	resulting In death) Last	Due	to (or ea e coris	equenca or).							
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be detached for us by Physician	Pert II. Other eignificant conditions	contributing to death but no	ot resulting in the	underlying cause	given in Part I.	23b. Did	tobacco uae co	ontributa to	the cause of deal		
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o Be	examiner?	Hospitai:	<b>Δ</b> ΠΕΔ/2 :		Other: 4 D Nursing H		- 1	has 10.	W 110 - 5 1		
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1	20 None and address of	0	(Ham On-) CT	a Deint'	10001				E, MD 212		
	30. Name and address of person with	to completed cause of deeth	(item 23a) (Typ	a / C+	Daul 1	)/ ;	RAH'	MAA	E MIN		
2	DHVID KIS	EDER9	30	1101	May 1	1 1	SHITI	MORA	1/1/2/2		
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cian			orah	John	con					Month	Day		Year	
dical	4a Facility Name (If not institution				.5011			lb City To	wn or Lo	Octobes ocation of Death			000 of Death	10:30 pm
iner	2917 A Fernan			,				Ft. N			10.0			unde1
al l	5. Social Security Number			Age (In yrs.	last birthday,		r 1 Year	If Under	24 Hrs.	8. Date of Birt	h .			lace (State or Foreightry)
r	<del>671</del> -68-5834		M 2 F 7	37	Yrs.	Months	Days	Hours	Min.	May 17		3	Jama	
	Usual Residence of Decedent													
	10a. State 10b. County	1		10c. Ci	ty, Town or L	ocation							1	Od. tnside City Limit
Directo	MD Anne	Arun	de1	Ft	. Mead	le								1 □ Yas 🗶 🗓 N
ś	10a. Street and Number					10f. Zi	Code				10g. Citiz	en of W	hat Coun	itry?
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	11. Marital Status		<ol><li>Was Decede Armed Forca</li></ol>	s?	,S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Ori an, Mexicar	igin? (Spi n, Puerto	ecify Yes or No- Rican, etc.)	1		k, White,	an Indian, etc.
	1 ☐ Never Married XX Mar 3 ☐ Widowed 4 ☐ Divorces		1 ☐ Yes ZXXNO If Yes, Give Yaar or Dates:			ŹŒNo	Specify:			Specify: Black		ack		
	15. Deceder			5.	16a Dece	edent's Usu	al Occup	etion	-		16h Kin	d of Bus	siness/inc	
	(Specify only highe		completed)		(Give	kind of wo	ork dona d	during mos	t of work	ing	100.11			,
	Elementary/Secondary (0-12)		College (1-4d	or 5+)		hier					Ret	ail		
	17. Father's Name (First, Middla,	Last)						18. Mothe	er's Name	e (First, Middle,	Maiden S	Sumame	a)	
	Marcus Grant							Eva	a Wil	lson				
	19a. Informant's Name/Reletion:	ship (Typ	e, Print) ( Hus	(band)	19b. Mait	ing Addres	s (Street	and Numb	er or Run	al Route Numbe	r, City or	Town,	Stete, Zip	Code)
	Michael Anthon			bana,	2917	A Fe	ernan	dez (	Court	t, Ft. N	leade	, M	D 20	755
	20a. Method of Disposition	- 5-		20b. F	Plece of Disponentery, cre	osition (Ne	me of	(e)		Date	20c. Loc	ation - (	City or To	own, State
	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		moval from Sta	181						10/18 2000	Oran	ige '	Texa	S
21. Signature of Funeral Service Licensee 22. Name and Address of Facility														
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	23a. Part1. Entar the diseasa, o shock, or heart faiture. Lis	r complic	ations that caus	sed the deal	th. Do not en					e, Annar or respiratory ar		5 , 141.	D 21	Approximate Interval Between
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5	resulting in deeth)			Due to (	or es à conse	quenca of)								
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	examiner?		ospital:	atiant 2	ER/Outpatie	ent 3 D	OA Oth	er:	ursing Ho	V		Othe	er (Specif	(v)
•	27. Manner of Death  1 Natural 5 □ Pendi	unner of Death  28a. Dete of Injury (Month, Day Year)  Natural 5 □ Pending  28b. Tir		28b. Time of Injury	-	28c. Injur Wor	y at		28d. Describe				,,	
	3 ☐ Suicide 6 ☐ Could	Suicide 6 Could not be								28f. Location (S City or Tox			er or Rura	al Routa Number,
		na Physi		of examine						end due to the red at the time,				
edical certification:							c licens	e number			-0101	- slave s	1 (Month	D V1
3	(Check only 2 Medical	Examine				29	C. LICOTIS	0 110111001			29d. Date	signed	a francistari,	Day, Year)
3	(Check only 2 Medical one)	Examine				29	) /	219	81		/3	e signed	T	O O
	(Check only 2 Medical one)	Examine ND		f deeth (Iter	n 23a) (Tvpe	Print)	) (	219	81		13	Signed	T	Day, Year) O O W. M. sydin

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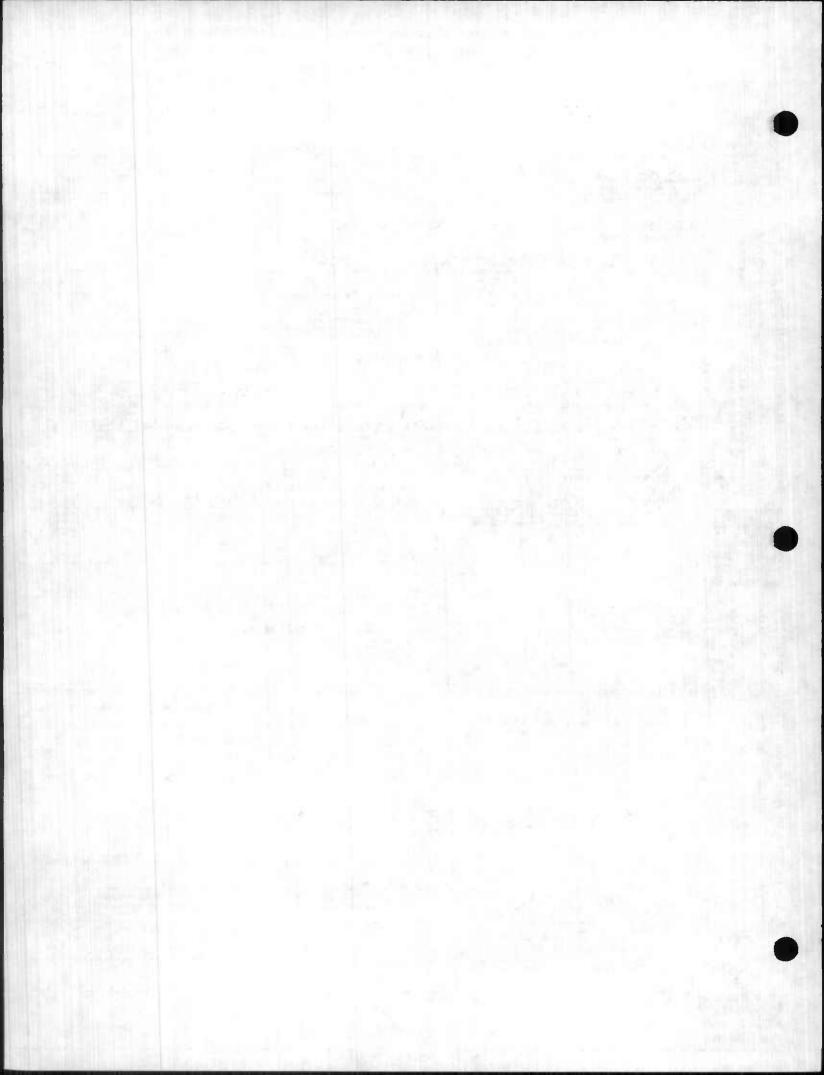
			Certificate of Death	F	leg. No.	02301
	St		Decedent's Name (First, Middle, Last)	2. Date of Dea Month	th	3. Time of Death
	Physicia /Medica	al	CHARLES THOMAS KOCHER, SR	CCTOCI	R14, 20	000 11:45 AM
	Examine	er	4a Facility Name (If not institution, give street and number)  4b. City, Town, or Lo	cation of Death	4c. County of	Death
1	Euporal		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day	JAM	9. Birthplace (State or Foreign
	Funeral Director		188-09-5609 190 M 2□ F 82 Yrs. Months Days Hours Min.  Usual Residence of Decedent	NOV. 2	4 9 9 17	Pennsylvania
	how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	the Maryler 28a-f ahon	cto	Md. Harford Bel Air			1 Yes 218 No
	ours ofter deeth with the Maryland alt, or Herra 23s or 28=1 show Examiner must be notified at	Funeral Director	10e. Street and Number 10f. Zip Code 2/0/5		10g. Citizen of Wh	nat Country?
		nue	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Views) Armed Forces?  14. Was Decedent of Hispanic Origin? (Specific Views) Armed Forces?	ecify Yes or No- Rican, etc.)	14. Race Black	- American Indien, , White, etc.
020	hours efter tural', or le	by F	1 □ Never Married 2 Merried 1 □ Yes 2 Mo Specify: 1 □ Yes 2 No Sp		Specify:	WHILL
21215-0020	n 72 hours	ted	15. Decedent's Education  16e. Decedent's Usual Occupation  (Size kind of unit does during most of work)	inc	16b. Kind of Bus	iness/Industry
21	within 7 ene. then n	Completed	(Specify only highest grade completed)  [Give kind of work done during most of working the completed of the complete of th	og.	RailRe	and
	be filed within tal Hygiene. Id other then event, the Me		17. Father's Name (First, Middle, Last) / 18. Mother's Name	(Eiret Middle		
Maryland	should be filed within nd Mental Hygiene. marked other than matic event, tra the	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name  Management	Ada	MORI	
ary	ges 1 end 2 should t of Health and Mer if item 27 ie marke or other treumatic	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura	al Route Numbe	r, City or Town, S	itale, Zjp Code)
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Baltimore,	permit. Pages 1 end Department of Health mportant: If Item 27 any injury or other tr page.		20a. Method (Disposition  1 Burial 2 Cremetion 3 Removel Irom State	Date Date	20c. Location - C	City or Town, State
Ĕ	Pa ant:		4 □ Donation 5 □ Other (Specify)	2000	FORST	HUL MARYLAGO
Balt	permit. Pag Department Important: I any injury o		21. Sin untuin Furnerel Service Locatisee 22. Name and Address of Facility	CHAPS	1-B2	AIR, P.A.
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	death cert e attendin id for use	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did t	obacco uaa conf	tributs to the cause of death?
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	iew requires that as been signed b 2 should be deta	S P	SICIC SINUS SYNDROME  ATRIAL FIBRILLATON			
oro	neen s hould	Completed	AMIAL FIBRILLATON	24a. Was	an autopsy med?	24b. Were autopsy findings available prior to completion of cause
Sec	@ W CV	ğ.				of death?
10	icten: The lev certificate has rector, page 2		25. Was case referred to medical 26. Place of Deatl	101		1 Yes 2 No
Division of Vital Records,	Physician: The in this certificate har ral director, page	To Be	examiner? Hospital: Other:		ne) lenca 6 □Othe	(Specify)
10	는 부를		27. Manner of Death 28a. Dete of Injury 28b. Time of 28c. Injury at		now injury occurre	· · · · · · · · · · · · · · · · · · ·
io	Attending or death.  ector: After by the fune	ate	2 Accident investigation M 1 Yes 2 No			
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	Fun Fun etely	edicai	29e. Certifier  (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, (Check only one)  13 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and the place of the place	ed at the time,	date end plece, e	nd due to the cause(s)
	To the Hospital or Attending I within 24 hours after death. It he Funerei Director: After ministely filled in by the funer	×	29b. Signeture end title of certifier 29c. License number		29d. Date signed	(Month, Day, Year)
	20		Dean Clean 40. 00016036		OctoBE	R, 16, 2000
	110	1	30. Name end address of person who completed cause of death (Item 23a) (Type, Print)	0		
	2	/	DR DEAN VASSAR, M.D. 104 PLUMIRE	E Koy	90	
	Stat Registra		31. Date filed (Month, Day, Year)  QCT 18 2000  32. Registra's Signature  4. Logaria			
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State of Maryland / Department of Health and Mental Hygiene 32932

Certificate of Death

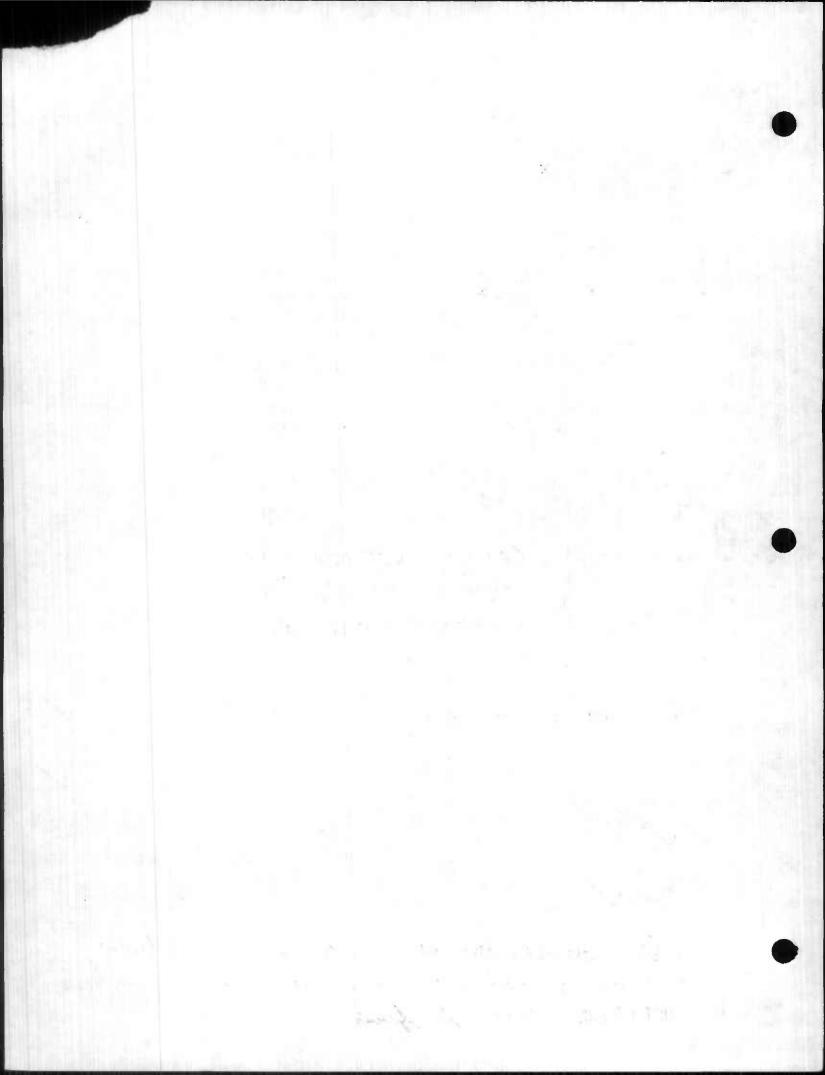
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ivsician.	1. Decedent's Neme (Fin	rst, Middle, Las	st)		8 7 1		2. Date of Month	Death Dev	3. Time of Death
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Medical caminer	4e Fecility Name (If not					4b. City, Town	n, or Location of De		
	LORISAF	BOOK	FORD NUR	21-10.7	NER	BALTE	moRs		
eral	5. Sociel Security Number	er 6. S	ex 7. Age (In y	rrs. last birthdey)	If Under 1	Yeer If Under 24		Birth Dey, Year)	9. Birthplace (State or Fore
ctor	213 05 608	4 1	DM 20F 35	Yrs.	Months	Deys Hours	Min. (Month,		TARYLANO
	Usual Residence of Dec	edent						1	
rector	10a. Stete 10b	o. County	10c.	City, Town or Lo	ocation				10d. Inside City Limi
to	Mersharo			BALT	E MOR	7			15€ Yes 2 □ 1
Directo	10e. Street and Number				10f. Zip 0			10g. Citizen of V	/het Country?
	5009	FRAC	KEDRO AV			21202		2.11	Α.
Funeral	11. Merital Stetus	1145	12. Was Decedent Ever in	n U,S. 13.	Was Decede	ent of Hispanic Origin	n? (Specify Yes or		- American Indian,
	1 Never Merried	2 Merried	Armed Forces? 1 ☐ Yes ② No			y Cuban, Mexican, I	rueno rican, etc./		k, White, etc.
by	3⊠ Widowed 4□	Divorced	If Yes, Give Yeer or Detes:		1□ Yes 2	No Specify:		Specify	STIHW
Completed	15.	Decedent's Ed	Jucation	16e. Dece	dent's Usuel	Occupation	d considera	16b. Kind of Bu	
ple	(Specify of Elementery/Seconder	nly highest gra	College (1-4or 5+)	life.	DO NOT use	Occupation done during most of retired)	or working	roso G	PALTIMORE
E	8465	y (0-12)	College (1-40/ 3+)	MACH	Fins	OPSRA	TOR	PR	21.2
BeC	17. Father's Neme (First	i, Middle, Last)				18. Mother's	s Name (First, Mide	dle, Maiden Sumem	е)
ToB	Mas	150	CHRIS	_		150	a asa	DAT	0.213
-	19e. Informant's Neme/I	Reletionship (			ng Address (	Street and Number	or Rural Route Nu	mber, City or Town,	State, Zip Code) 3178
	Varilles	1 0	nevasi	wil	Jane (	270:00	122001	Westerly	2110 had 2
	20e. Method of Dispositi	ion		b. Plece of Dispo	sition (Nem	9 01	Dete	20c. Location -	City or Town, Stete
			Removei from Stete	b. Place of Disposicemetery, crem	metory or off	Jei brack OIT -	- OCE18		F. 1 ( )
once.	4 Donetion 5 D			BIHLES	16.6	4.	3000	1-0000	4177 1 186178
DUC.	21. Signature of Euneral	Service Liber	300	5	2. Name end	Address of Fecility	24 W76	ORIES	21231
OI .	Dec 1	Store	1			HARFOR		11 01.	DAIRSAN ELL
	23e. Pert1. Enter the dis	seese, or com	plications that caused the done cause on each line.					y errest,	Approximate Intervel Between
n									Onset end Death
al	Immediate Cause (Final disease or condition	,		Sers	15				DAYS
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Examir	Sequentially list condition	000	b. — Due to	CACH o (or es e consec					The CAN
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8	cause. Enter Underlying Ceuse (Diseese or injury that initiated events		Due to						
edical	Sequentially list condition if any, leading to immed cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last		Due to	(Or as e conseq					
2	cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last	1	d.	(0) 45 6 0011364					
2	resulting in death) Last	ι	d		ndarhina ce	uea riven in Part I	235 f	ild tobacco uses con	atchute to the cause of deep
2	resulting in death) Last	ι	d		inderlying ca	use given in Pert I.			atribute to the cause of dea
Physician/M	Pert II. Other significant	t conditions co	d	resulting In the u	inderlying ca	use given in Pert I.			atribute to the causs of dear
by Physician/M	Pert II. Other significant	t conditions co	dontributing to death but not	resulting In the u	inderlying ca	use given in Pert I.	1		3 Probably 4 Unknot
by Physician/M	Pert II. Other significant	t conditions co	dontributing to death but not	resulting In the u	inderlying ca	use given in Pert I.	24e. W	☐ Yss 🏂 No	Probably 4 Unknow  24b. Were autopsy finding aveilable prior to completion of cause
by Physician/M	Pert II. Other significant	t conditions co	dontributing to death but not	resulting In the u	inderlying ca	use given in Pert I.	24e. W	Yss 28 No	3 Probably 4 Unknot
Physician/M	Pert II. Other significant	t conditions co	dontributing to death but not	resulting In the u	inderlying ca	use given in Pert I.	24e. W	Yss 25 No	Probably 4 Unknow  24b. Were autopsy finding aveilable prior to completion of cause
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Certification: To Be Completed by Physician/M	Pert II. Other significant  25. Wes case referred to exeminer?  1   Yes   25   No  27. Menner of Death 120 Nature  5   2   Accident 3   Suicide 6   4   Homicide	o medical  Pending investigation  Could not be determined	d	resulting In the u	nt 3 DO/	26. Place of A Other: 4 2 Nurse work? 1 Yes 2 Notice	24e. W point of Death (Check on Sing Home 5 - R 28d. Descrit 0 28f. Location City or	Yes No No No an autopsy enformed?  Yes No	3 Probably 4 Unknown available prior to completion of cause of death?  1 Yes 2 No  er (Specify) ed  er or Rurel Route Number,
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edical Certification: To Be Completed by PhysiciaryM	Pert II. Other significant  25. Wes case referred to exeminer? 1   Yes   Yes   No  27. Menner of Death 1   Naturel   5   2   Accident   3   Suicide   6   4   Homicide  29e. Certifier (Check only one)	o medical  Pending investigation Could not be determined  Certifying Phy Medical Exam	d	resulting In the u	nt 3 DO/f 28 M reet, fectory, h occurred el vestigetion, i 29c.	26. Place of A Other: 4 2 Nurse of Nurs	24e. W point of Deeth (Check on Sing Home 5 - R 28d. Descrit 0 28f. Location City or	Yes No No No seriormed?  Yes No No No seriormed?  Yes No No No seriormed?  No	3 Probably 4 Unknown aveilable prior to completion of cause of death?  1 Yes 2 No  er (Specify)  ed  er or Rurel Route Number,  nner as stated. and due to the ceuse(s)  d (Month, Day, Year)
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edical Certification: To Be Completed by Physician/M	Pert II. Other significant  25. Wes case referred to exeminer? 1   Yes   Yes   No  27. Menner of Death 1   Naturel   5   2   Accident   3   Suicide   6   4   Homicide  29e. Certifier (Check only one)	o medical  Pending investigation  Contifying Phy Medical Exam	d	PER/Outpatier  2 ER/Outpatier  28b. Time of Injury  at home, ferm, strectly  knowledge, deett inetion end/or in	nt 3 DO/f 28 M reet, fectory, h occurred el vestigetion, i 29c.	26. Place of A Other: 4 2 Nurse of Nurs	24e. W point of Deeth (Check on Sing Home 5 - R 28d. Descrit 0 28f. Location City or	Yes No No No seriormed?  Yes No No No seriormed?  Yes No No No seriormed?  No	3 Probably 4 Unknown aveilable prior to completion of cause of death?  1 Yes 2 No  er (Specify) ed  er or Rurel Route Number, anner as stated. and due to the ceuse(s)



State of Maryland / Department of Health and Mental Hygiene

32933 Certificate of Death 1. Decedent's Name (First, Middle, Last) Month 10 2. Dete of Death 3. Time of Death 12Day **Physician** Michael L. Kaitis 2000 5:40 pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Heritage Nursing Home Dunda1k If Under 24 Hrs 8. Date of Birth (Month, Dev. Year) 04/25/1912 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 100 M 20 F Months Days Hours Yrs. 198-10-3059 88 Greece Director Usual Residence of Decedent 10a. Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow other traumatic avant, the Medical Examiner must be notified at 1 Yes 2 No MD Directo N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6 727 Ponca Street 21224 238 United States Funeral Pages 1 and 2 should be filed within 72 hours aftar death vant of Haalth and Mental Hygiana. ant: If Item 27 is marked other than "natural", or Itema 23. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Never Merried 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales-Restaurant Il Hygiana. College (1-4or 5+) Elementary/Secondery (0-12) Salesman Equipment 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Leonidas Kaitis Argyrio Cladias 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health a Important: If Item 27 is any injury or other tra-727 Ponca Street, Baltimore, MD 21224 Despina Kaitis Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremetion 3 ☐ Removal from State Greek Orthodox Cemetery 10/16/00 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton-Matthews Funeral Home, Inc 2134 Willow Spring Road Dundalk, MD 21222 21. Signeture of Funeral Service Licenses tru 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical CONGESTIVE Examiner Physician/Medical Examiner The law requires that the death certificate be axecuted usa as the burial-tran Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury 1ABETES Box 68760, physiclan ME that initiated events resulting In death) Lest Due to (or es e consequence of) MENTIA P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown THRIVIS Division of Vital Records, Medical Certification: To Be Completed by staty filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? E JNO 1 Yes 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Aftar this 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation s aftar daath. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29d. Dete signed (Month, Dey, Year) 29c. License number 1/2 29b. Signature and title of certifier e i ulle Neo 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Love Saltenere Mo 2122 . 1 Jule 31. Date filed (Month, Day, Year) OCT 1 8 2000 32. Registrar's Signature State Registrar



Baltimore, Maryland 21215-0020

**Physician** /Medical

Examiner

Directo

Funeral

à

To Be Completed

**Funeral** 

Director

with the Maryla

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or flams 23s or 28s-f show any Injury or other treumatic event, the Medical Examines must be notified at

	Please	e Type or State o		d / Depa	artmer	nt of H		and M	Mental Hyg	giene [		32934
1. Decedent's Name	(First, Middle, L	Last)	5		Timou	1001	Death		2. Data of Deal		V-201	3. Time of Death
LOUI	.S EDWARD	D KREINER	. SR						October	16,2000	O Year	2:20AM
4a Facility Name (11) Stella M	Maris Hosp	oice	mber)			-	Timoniu	um	ocation of Death	-	ty of Death altimor	re
5. Social Security Nur 217-18-5313 Usual Residence of D		Sex 1 M 2 F	7. Age (In yrs. la	last birthday) Yrs.	f Unda Months	ar 1 Year s Days		24 Hrs. Min.	8. Date of Birth (Month, Day)	y, Year)		place (State or Foreign intry) yland
	10b. County	- HE	10c. City	y, Town or Lo	ocation						1	10d. Inside City Limits
Maryland	Baltimon	re	Towso	n								1 🗆 Yas 2 🗆 No
10e. Street and Number 44 Acom Cin	iber					21286			1	10g. Citizen of USA	What Cour	
11. Marital Status  1 Nevar Married  3 Widowed 4	701	Armed Fo	2□No WWI	II	If Yes, spe	ecify Cuba	ban, Mexican	n, Puarto	pecify Yes or No- Rican, etc.)		can Indian, , atc. hite	
	1		)	(Give	DO NOT	vork done use retired	during most ed)	t of work	ling	16b. Kind of B		
								ne (First, Middle, I e Gousman	Maiden Sumar	ama)		
19e. Informant's Nen Louis E Krei	iner Jr	(Type, Print)	Son	2334 [	Dale Dr	rive F			ral Routa Number	ia 22043		
4 Donation 5	Cremation 3 l 5 Other (Spec		State	Pleca of Disponentery, cre	ematory or Redeems	rothar plac			- ^	Baltimon		
21. Signature of Fundamics	Step	lenge	enak	1 6	6500 Yo	ork Ro		Mi Itimon	re, Maryla	and 21212		al Home Inc.
23a. Part1. Enter the shock, or heart Immediate Cause (F disaasa or condition	t failure. List only	ily one cause on e	each line.	h. Do nol an								Approximate Injerval Between Onset and Death
resulting in death)	21 16		Due to (or	R or as a conse	quence of	):						
Sequentially list conditions, leading to immoduse. Enter Underly Cause (Disease or In	mediate	b	Due to (or	er as a conse	quenca of)	):						
that initiated events resulting in death) La		d	Due to (or	r as a consec	quence of)	ŗ.					1	
Part II. Other signific	ant conditions	contributing to de	eath but not resu	ulting in the (	undarlying	cause giv	ven in Part I			tobacco use co Yss 2 No		to the cause of death?
										an autopsy med?	av	Vere autopsy findings vailable prior to ompletion of causa f death?
									1 🗆 Y	Yes 2 No	1	□Yes 2□No
25. Was casa referre	ed to medical							e of Deat	th (Check only or	ine)		
1 ☐ Yes 2 👿 N	lo	1		<b>ER/Outpatie</b>		DUA		ursing Ho	oma 5 Resid	Jenca 6 70	ther (Speci	HOSPICE
27. Manner of Death 1 X Natural 2 ☐ Accident	5 Pending investigation		of Injury nth, Dey Year)	28b. Time o Injury	of M	28c. Injur Wor	ury at ork? □ Yes 2 □		28d. Describe h	ow injury occu	med	

**Physician** 

/Medical Examiner

Be Completed by Physician/Medical Examiner

29a. Certifier

2 Accident 3 Suicide

4 Homicide

To the Hospital or Attanding Physician: The law requires that the death certificate be executed that he hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunat-transit Division of Vital Records, P.O. Box 68760,

Medical Certification: To

State Registrar

31. Date filed (Month, Dey, Year)

29c. Licensa number 29b. Signature and title of certifier

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

D43725

1X Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

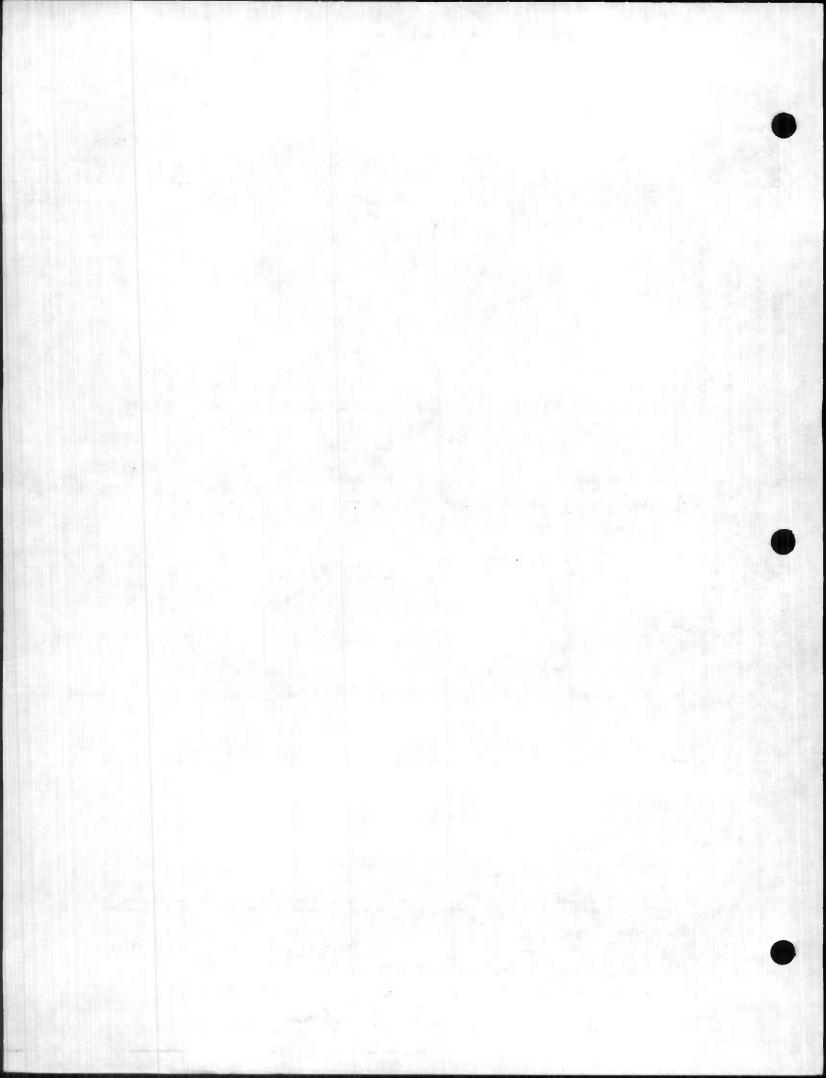
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Dale signed (Month, Day, Year) 10/17/00

28f. Location (Street end Number or Rural Route Number, City or Town, State)

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32. Registrar's Signature

6 Could not be determined



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 3 2 9 3 5

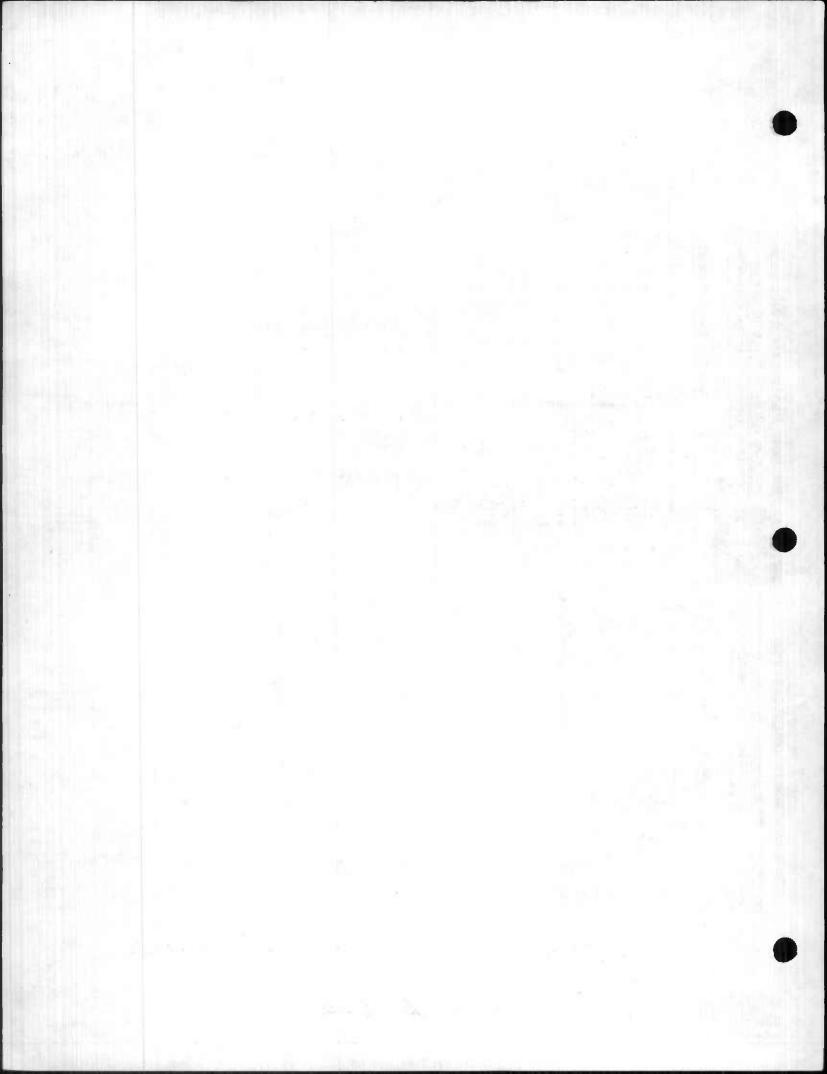
					C	ertificate	e of	Death		Reg. No.			
sician	1. Decedent's Nem	e (First, Middle, Last	)						2. Date of D	Death Day	Year	3. Time of Death	
dical	GLORIA	A B. MAAS							111	per 15	2000	3:50 Ar	
niner	4a Facility Name (	If not institution, give	street and nur	mber)				4b. City, Town, or L	ocation of Dea	ath 4c. Cou	nty of Death		
	Frank	in Square	Hasi	pital (	Cent	er		Roseda	le	Bar	Limor	2	
al	5. Social Security N		M 2DF	7. Age (In yrs.		y) If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of B	Dav. Year)	9. Birth	place (State or Foreign	
	213-80-	3193	JW ZELF	72	Yrs.				Aug 1	6, 1928	Ala	aska	
	Usual Residence of 10a. Stete	10b. County		10c. Cit	ty, Town or	Location					1.	10d. Inside City Limits	
5	MD					ltimor	e						
ect	10e. Street and Nur	mbar				101. Zip				10- Chiese	-4 lather Cour	27 -170	
Funeral Director		lliams Ave	enue					21221		10g. Citizen	USA	nity ?	
þ	11. Merital Status  1 Never Merri 3 Widowed	ied 2 Merried	12. Was Dece Armed Fo 1 Tyes If Yes, Giv Yeer or De	/8	J,S. 13	3. Was Deced If Yes, spec		dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	No- 14. F	Rece - Ameri Black, White, city: Wh:	etc.	
Be Completed	/Pnos	15. Decedent's Edu			16a. Dec	cedent's Usua	Occup	pation	kina	16b. Kind of	Business/In	ndustry UNK	
	Elementary/Seco	only highest grad ondary (0-12)	College (1	-4or 5+)				during most of world)	(=/y				
1	unk		nk		home health care								
00	17. Father's Neme	(First, Middle, Last)	unk		18. Mother				e (First, Middl	lle, Maiden Surr	Sumeme) UNK		
0													
		eme/Relationship (T) .n Square		a 1				and Number or Run		Baltimo			
			nospica					1 Dquare 1				unk  ate, Zip Code)  MD 21237  ty or Town, State	
		position □ Cremetion 3 □ F 5 □ Other (Specify)			riece of Dis cemetery, ci	position (Nam rematory or ot	e or her pla	ce)	Date	20c. Locatio	n - City or T	own, State	
											imore	Street	
	1 an	Ronald S. Wade Director State Anatomy Board 655 W. Baltimore, MD 21201  11. Enter the disease for complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, ock, or heart failure. List only one cause on each line.	THOTE	Sticet									
	23a, Pert1, Enter th			Approximate									
	shock, or hea	rt failure. List only or	ne cause on e	ech line.							Onset end Deeth		
	Immediate Cause (	(Finel	.00	- 1 - 1			0					_ 1.0	
	disease or condition resulting in death)	n	Met	astat	PIC L	-ung	C	will			-	o months	
CAGIIIII				Due to (d	or as a cons	equence of					1		
	Immediate Cause (Finel disease or condition resulting in death)  a. Metastatic Lung Concor  Due to (or as a consequence of b.												
	Sequentially list con if any, leading to im- cause. Enter Unde Cause (Disease or	nmediate		Due to (c	es e CUIS	~quonoe on;							
	that initieted events		C	Due to fo	Y as a cons	equience of.							
	resulting in death) l	Last		Due to (or as a consequence of):									
			d										
	Part II. Other election	icant conditions cor	ntributing to de	ath het not me	ulting in the	underlying	use of	ven in Pert I	23h Di	d tobacco use	contribute 1	to the cause of death	
	, as ii. Cam agiiii	TOWN CONTROLLED CON	madeling to de	ALAT DUA HOL195	ronning III II/18	underlying Ca	nad Au	out at Coll.		Yes 2 N			
									,	2010	00110	- Contaion	
									24a. We	es an autopsy rformed?	a\ cc	Vere eutopsy findings vailable prior to empletion of cause	
deligion of the second											of	death?	
									10	Yes 20 No	1	☐ Yes 2월 No	
	25. Was case reference examiner?		locaital: 4				100	26. Place of Dea	th (Check only	y one)			
0	1 ☐ Yes 2 🗷	NO			ER/Outpati			4 LI Nursing H		sidence 6 🗆		ify)	
Certification:	27. Manner of Death	5 Pending	28a. Date of	of Injury th, Day Year)	28b. Time Injury		Sc. Injui		28d. Describe	e how injury oc	curred		
Cat	2 Accident	investigation 6 Could not be				М		Yes 2 No					
10.00	3 Suicide 4 Homicide	determined	28e. Place buildir	of Injury - At hong, etc. (Specif	ome, farm, : fy)	street, factory,	office			(Street end Nu Town, State)	mber or Rur	rel Route Number,	
edical C	29a. Certifier (Check only one)	1 Certifying Phys	ner: On the ba	sis of examina	owledge, dea	ath occurred a investigation,	t the tir	me, date and place, opinion, death occur	and due to the	ne cause(s) and e, date and place	manner as a	stated. to the ceuse(s)	
Med	29b. Signature and	title of certifier	and menn	er steted.		290	Licens	se number		29d Data sin	ned /Month	lace (State or Foreign Intry) IS ka  10d. Inside City Limits IS Yes 2 No Intry?  Is an Indien, etc. It e  dustry UTI k  In k  10d. Inside City Limits IS Yes 2 No Intry?  Intry?  In the cause of death?  Interval Between Onset end Deeth  Interval	
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1	hein	Mou	4 (a)	D.O.			00	55843	)	10/15	100		
1	30. Maryé and addre	ess of person who co		e of death (Item	n 23a) (Typ	e, Print)	_		-	'	,		
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DHMH 16 Rev 6/95

State

Registrar

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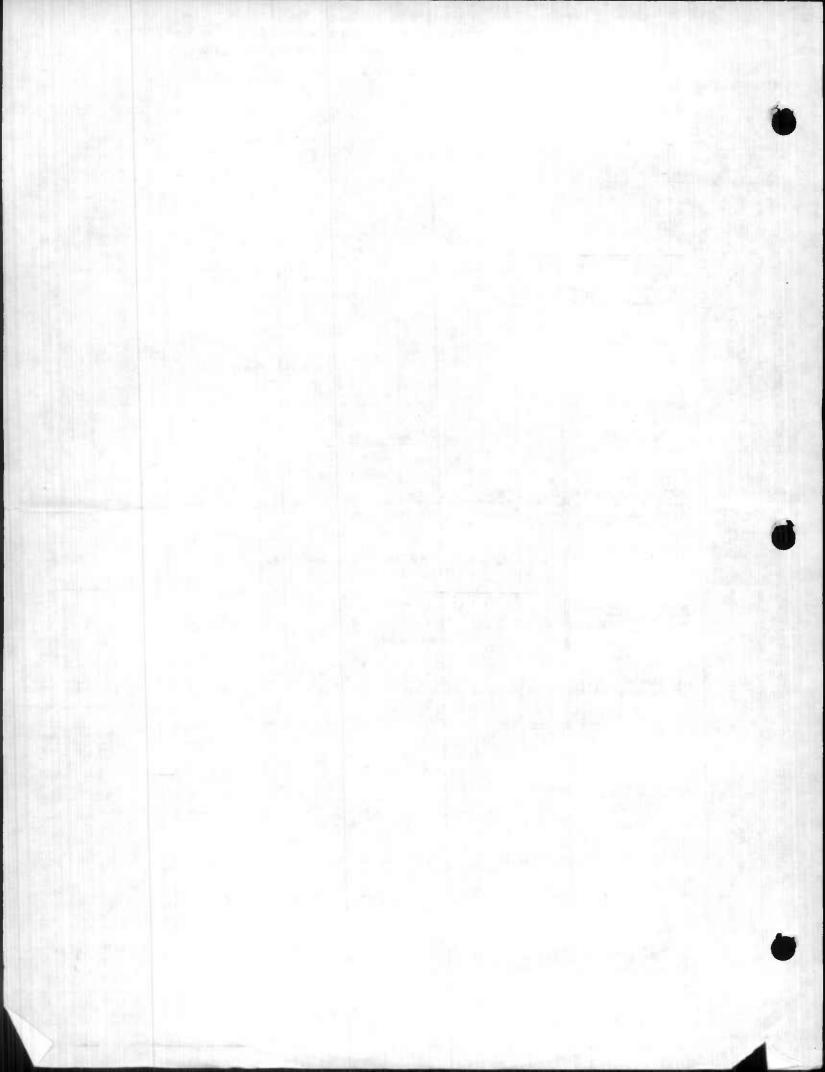


State of Maryland / Department of Health and Mental Hygiene
Amend Item # 10e,23b,23II,24a, G788,10/27/00,per Dr,FH,Ga©ertificate of Death

32936

Physician	0,2011,240, 0,00,	10/ 2// 00 spc.		COLI	moun	01	Death		Reg. No.		
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/Medical WA/	VDA MARI	IKLE						OCTOBER	146	000	07:05
Examiner 4a Facili	ty Name (If not institution, giva						4b. City, Town, or	Location of Death	4c. County	of Death	
Le	vindale Nursin	g Home					Baltimo	ore	N/A		
Funeral 5. Sociei	Security Number 6. Sa		e (In yrs. lasi	birthday)	If Undar Months	1 Yaar Days	If Under 24 Hr		h V Vesti	9. Birthpla Countr	ca (Stata or Fora
Director 042-	09-3411	DM 2XX 8	8	Yrs.	MORRIS	Days	Hours Will	Septembe	r 4,1912		chusetts
Usuel Ra	sidance of Decedant										
10a. Stat	ta 10b. County		10c. City, T	own or Loc	ation					100	d. Inside City Limi
Mary	land N/A		Bal	timor	е						XX Yes 2DN
£ 8 2 10e. Stre	et and Number 310 Rid	gemede Road			10f. Zip	Coda			10g. Citizan of V	Vhat Country	y?
1 8 G -441	5 Wickford Roa	d			212	210			USA		
10a. Stat  Maryland  Maryl	al Stetus	12. Wes Decedent	Ever in U,S.	13. W			lispanic Origin? (	Specify Yas or No rto Rican, etc.)		e - America	
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Joh	n Shellow						Zofi	ia Madei			
place Sold Market Market Sold	ormant's Name/Ralationship (T)	voe. Print)		19b. Mailing	Address	(Street		Rural Routa Numbe	er. City or Town.	Stata, Zip C	Coda)
Hele	n M. Passano		DTR					Baltimore			
THE 20a Mat	hod of Disposition		20b. Plac	e of Dispos etary, cram				Data	20c. Location -		
Pages nent of 1	Buriel 2 X X rametion 3 1							0 40 00			
nit. Pagartment portant: Injury of	Donation 5 ☐ Other (Specify,		Gree	nmoun				10-18-00	Baltim	ore, N	Maryland
permit. Pages 1 a Department. If Item any injury or othe 2008.	ature of Funeral Service Licens	9 1/	1	22. Nama and Addrass of Facility Mitchell-Wiedefeld Funeral Home							Home Inc.
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23a. Par	rt1. Entar the diseesa, or comp	lications that caused	tha death.							1 -	Approximate Interval Between
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/Medical Immedia	ata Causa (Final		14.00								
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death cert death cert and for use at for use be attending by the strength of t							1000			1	
Completed by Physiciar	ther significant conditions co	entributing to death b	ut not rasultir	ng in tha un	darlying c	ausa gi	ven in Part I.	23b. Did	tobacco use co	ntributa to	the cause of dea
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bed by	.ozo iwopiicozy z	failure								1	
requires ween sign hould be								24a. Was	an autopsy rmed?	avai	e autopsy finding lable prior to
as be 2 sh					-					of de	pletion of cause eath?
The la page								DOX.	Yes ZZINO	10	Yes 28 No
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25. Wes exam	nar of Death	(Month, Da	y Year) ury - At home	Injury	М	1 🗆		281. Location ( City or To	Street and Numl wn, Stata)	per or Rural	Routa Number,
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within 24 hours after death.  To the Hospital or Attanding Physician.  To the Funeral Director: Aftar this certific completely filled in by the funeral director.  Medical Certification: To Be  Medical Certification: To Be  Say.	Natural Accident Suicide Homicide Suicide Homicide Set only 2 Medical Examination of the Certifying Physics of the Certifier Physics of the Ce	28a. Piaca of Injuliding, etc. visician: To the best of iner: On the basis of and manner sta	ury - At home c. (Specify) of my knowle examination ated.	Injury  I, farm, stra  dge, death a end/or invo	M at, factory	1 at the ti	ma, data and pla opinion, daath occurs	City or To	cause(s) and midata and place,	annar as sta and dua to d (Month, D	ited. tha cause(s)
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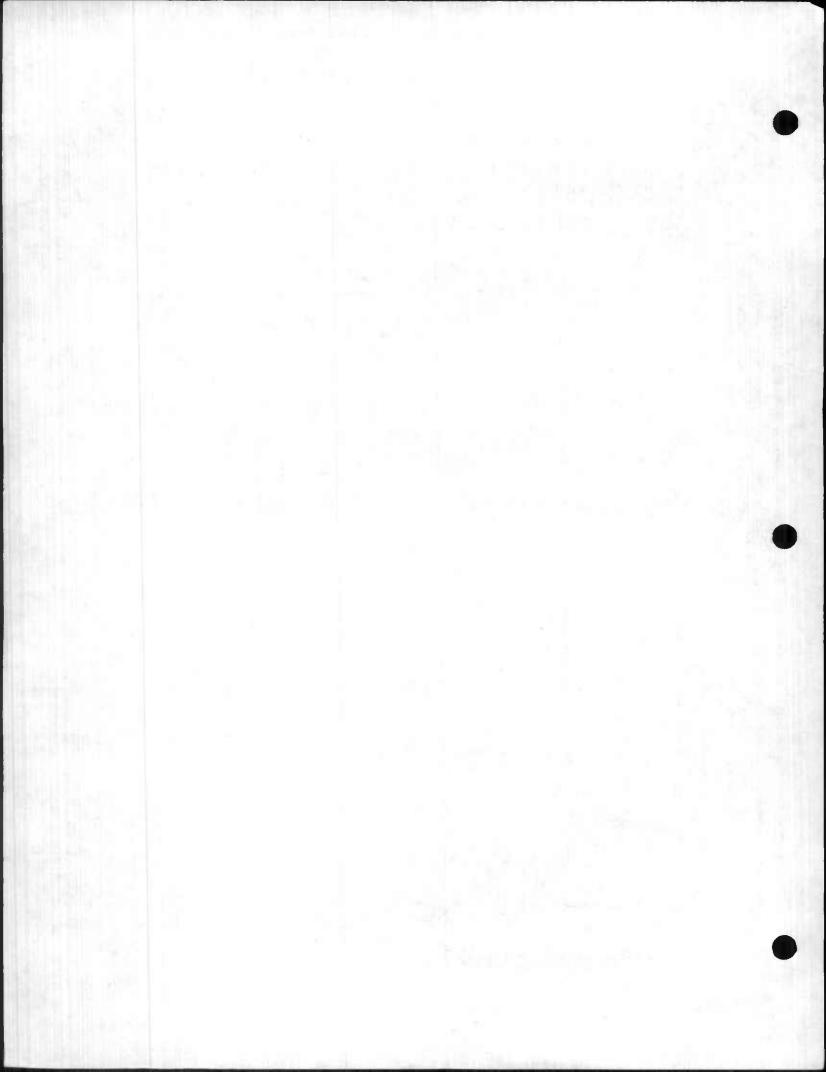
**ORIGINAL** 



State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death October 16, 2000 **Physician** LUCILE KEMP MUELLER 6:15PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Lutherville Baltimore Brightwood Nursing Home If Under 24 Hrs. 8. Date of Birth (Month, Dey. Year) July 31,1906 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10 M 20 F Months Hours Yrs. 212-30-5642 Director Tennessee Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. tosida City Limits permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Exercises in mant to notified. 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1917 Ruxton Road 21204 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 200 No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2XX No Specify: Specify. þ XX Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) Teacher Baltimore County Board of Ed. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thayer Alfonso Kemp Susan Berthel Wiggins 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant'a Name/Ralationship (Type, Print) Mary M. Greenwood DTR 1917 Ruxton Road Baltimore, Maryland 21204 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata Burial 2 Cremetion 3 Removal from State Moreland Memorial Park 10-20-00 Baltimore, Maryland 4 □ Donetion 5 □ Other (Specify) 22. Neme and Address of Facility 21. Signature of Funeral Service Licenses Mitchell-Wiedefeld Funeral Home Inc. Menakers 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complicefions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Respiratory Examiner multi-infarct dementia Years Examin attending physician and for use as the bunial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury thet initiated events resulting in death) Lest Box 68760. Physician/Medical Due to (or as e consequence of) 23b. Did tobacco use contributs to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown thyroidism Records. ğ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed After this certificate has 20 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was casa raferred to medical 26. Placa of Death (Chack only one) Hospitel: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Mospital or Attending P
 24 hours after death.
 Funeral Director: After the letaly filled in by the funeral purer. 5 Pending investigation 1 Yas 2 No 2 Accident 28f. Location (Streat and Number or Rurel Route Number, City or Town, Stata) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homiclde To the Hospital
Thin 24 hours a
To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end address of person who comp th (Item 23a) (Type, Print) Falls Rd Lutherville, MD 21093 1/my aura 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar

**DHMH 16 Rev 6/95** 

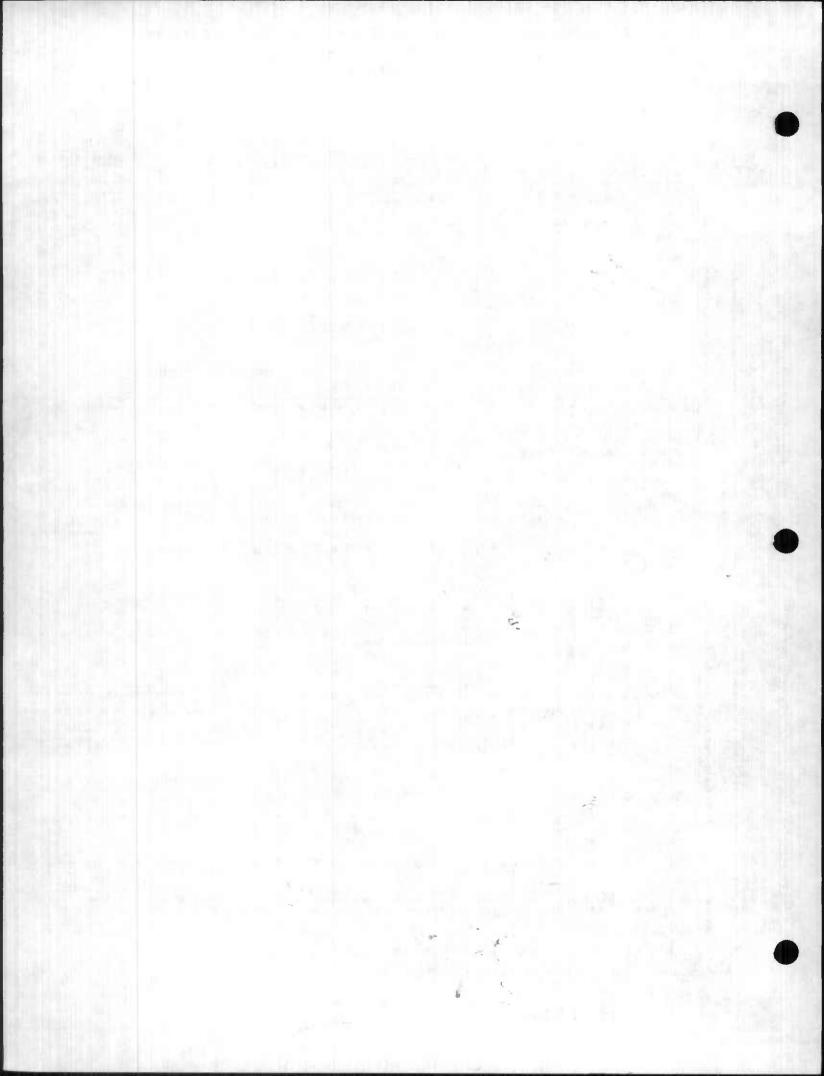
**ORIGINAL** 



State of Maryland / Department of Health and Mental Hygiene 0 32938

	Certificate of Death		Reg. No.	02300				
hysician	1. Decedent's Name (First, Middle, Last)	2. Date of De Month	Day Year	3. Time of Death				
ical	Harold E. Martin	Octobe		10.00				
niner		, or Location of Deat	4c. County of De	ath				
	North Arundel Hospital Glen B		Anne Aru					
	5. Social Security Number 6. Sex 1 Months 2 F 6. Sex 7. Age (In yrs. last birthday) 1 Under 1 Yeer 1 If Under 24 Months Days Hours 1	Hrs. 8. Date of Bir (Month, Da Oct. 2	th ly. Year) 9. B (7. 1932 Ir	inthplece (State or Foreign Country) ndiana				
	Usual Residence of Decedent							
Director	10a. State 10b. County 10c. City, Town or Location  MD Anne Arundel Odenton			10d. Inside City Limits 1 ☐ Yes 2 No				
5	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	Country?				
2	539 Saltoun Avenue 21113		USA					
by Funeral	11. Marital Stetus  1 Never Merried  1 Never Merried  3 Widowed 4 Divorced  12. Wes Decedent Ever in U,S. Armed Forces?  12. Wes Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P  12. Wes Decedent Ever in U,S. Armed Forces?  12. Wes Decedent Ever in U,S. Armed Forces?  12. Wes Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P  12. Wes Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P  12. Wes Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P  12. Wes Decedent Ever in U,S. Armed Forces?  12. Wes Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P  12. Wes Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P  13. Wes Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P  14. Wes Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P  15. Wes Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P  16. Wes Decedent Ever in U,S. Armed If Yes, Specify Cuban, Mexican, P  16. Wes Decedent Ever in U,S. Armed If Yes, Specify Cuban, Mexican, P  16. Wes Decedent Ever in U,S. Armed If Yes, Specify Cuban, Mexican, P  16. Wes Decedent Ever in U,S. Armed If Yes, Specify Cuban, Mexican, P  16. Wes Decedent Ever in U,S. Armed If Yes, Specify Cuban, Mexican, P  16. Wes Decedent Ever in U,S. Armed If Yes, Specify Cuban, Mexican, P  16. Wes Decedent Ever in U,S. Armed If Yes, Specify Cuban, Mexican, P  16. Wes Decedent Ever in U,S. Armed If Yes, Specify Cuban, Mexican, P  17. Wes Decedent Ever in U,S. Armed If Yes, Specify Cuban, Mexican, P  18. Wes Decedent If Yes, Specify Cuban, Mexican, P  18. Wes Decedent If Yes, Specify Cuban, Mexican, P  18. Wes Decedent If Yes,	? (Specify Yes or No Puerto Rican, etc.)	14. Rece - An Bleck, Wh Specify:	nerican Indien, nite, etc. Black				
	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of		16b. Kind of Busines	s/Industry				
	(Specify only highest grade completed)  Elamantary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of life. DO NOT use retired)	working						
	12 SFC		US Army					
מטור	17. Fether's Name (First, Middle, Last) 18. Mother's	Name (First, Middle	, Meiden Sumame)					
0	Theodore Martin Eliz	zabeth Hok	obs					
	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S						
	20e Method of Disposition (Name of	- 111	20c. Location - City of	or Town, Stete				
	1  Burial 2  □ Cremation 3  □ Removel from State	10/16						
Important: If itsm 27 any injury or other tr pncs.	4 □ Donation 5 □ Other (Specify) Maryland Veterans Cem.  21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral	2000	Crownsvill	.e, MD				
	P.A.							
	The learner 12 Ridgely Aver			1401				
Examiner	23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as ceishock, or heart failure. List only one ceuse on each line.  Immediate Cause (Final disease or condition resulting in death)  e.   CORONARY ARTERY	A-L 13	LEEDING	Inierval Between Onset and Death				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  b. Due to (or es a consequence ot):  C. Due to (or es e consequenca of):							
Physician/Medical	d							
2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23h Did	Did tobacco use contribute to the cause					
				Probably 4 Unknow				
	CARDIOMYOPATHY	_ ''	708 22110 30	Probably 4 onkilow				
	ARTERIAL HYPERTENSION		en autopsy 24b ormed?	Were eutopsy tindings evailable prior to completion of causa of death?				
Completed		10	Yes XXNo	1 ☐ Yes 2 No				
	25. Was cese referred to medical 26. Place of	Death (Check only	onel					
	examiner? Hospitel: Other:		idence 6 Other (Sp	paciful				
			how injury occurred	outy)				
	M 1 Vac 2 No							
	2 Accident investigation 3 Sulcide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or wn, State)	Rural Route Number,				
<i>y</i>	29a. Certifier  (Check only one)  112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and process of examination and/or investigation, in my opinion, death and manner stated.	plece, and due to the occurred at the time,	cause(s) end manner dete and place, and d	as stated. ue to the cause(s)				
	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	onth, Day, Year)				
	Daulous Holoamy M.D. D 3543	6	10.11.					
	b Care Care Care							
	30. Name and address of person who completed cause of death (filem 23a) (Type, Print), BARBARA KAUZNY H.D. 1132 AWNA POUS RD	DOFNIT	DAL HID	21113				
1		UNUIVIO	IN IND	01112				
te	31. Date filed (Month, Day, Year) 32. Registra's Signature							

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amend Items 1,17,18 per phy.,fd11/08/00dhibState of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month **Physician** Irving P. Meginnis 9A.M. Irving K. Meginnis Oct. 14, 2000 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nama (If not Institution, giva street and number) Examiner Anne Arundel 8175 Bodkin Ave. Pasadena H Under 24 Hrs. 8. Deta of Birth (Month, Day, Yaar) 2-21-1916 If Under 1 Yeer 7. Aga (In yrs. last birthday) Birthpleca (Stata or Foraign Country) 5. Social Security Number 6. Sex **Funeral** Days 1 MM 2□ F Months Yrs 84 213-03-5193 Maryland Director Usual Rasidence of Decedant 10c. City, Town or Location 10d Inside City Limits 10a State 10b. County 25a-f shor the Mary 1 Yes 2 No Director Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Harra 23a or jens. r than "netural", or items 23s or the Medical Examiner must be 8175 Bodkin Ave. 21122 U.S.A. Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 □ Yes 2 閏 No If Yas, Give Year or Datas: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxicen, Puerto Rican, atc.) Bleck, Whita, atc. hours after 1 □ Nevar Merried 2 □ Married Specify: White Maryland 21215-0020 1 Yas 2 No Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Owner Elementary/Secondary (0-12) Collega (1-4or 5+) 12 4 Photographer McGinnis Old Films 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maidan Surname) Be should be nd Mental is marked William B. Meginnis Paul Meginnis Unknown Ida Kohler 10 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Neme/Ralationship (Type, Print) Pages 1 and 2 si ment of Health an Department of Health a important: if Item 27 is any injury or other tran once. Casimer B. Zebron (Brother-in Law 8175 Bodkin Ave. Pasadena, MD. 21122 Saltimore, 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Buriel 2 ☐ Cremation 3 ☐ Ramovel from Stete 10-17-00 Balto., MD. 4 ☐ Donetion 5 ☐ Other (Specify) Holy Cross Cem. 21. Signature of Funaral Service Licenses 22. Nama and Addrass of Facility
McCully-Polyniak Funeral Home P.A. 3204 Mountain Rd. Pasadena, MD. 21122 23a. Pert 1. That the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on sech lina. Approximata Intarval Between Onset end Deeth **Physician** /Medical Immediata Causa (Final diseasa or condition rasulting in daath) Examiner Due to (or es a consequence of) Examiner burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Diseesa or injury that initiated events resulting in death) Last Due to (or as e consequance of): Box 68760. signed by the attending physicien d be detached for use as the buna Physician/Medical Dua to (or as a consequence of) Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the cause of death? P.O. 1 Yas 2 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Were eutopsy findings 24e. Was en autopsy available prior to completion of ceuse of death? 1 ☐ Yas 2 No certificate To the Heaptul or Attending Physician:

Applied 24 Journ after death.

On the Funeral Director: After this certition
completely fixed in by the funeral director. 25. Was case referred to medicel axaminar? Be 26. Piaca of Deeth (Check only ona) 1 Yas 2 No Hospitat 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify)

Injury at 28d. Describe how injury occurred 2 27. Mennar of Death
1 Naturat
2 Accident 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) 28b. Tima of Certification: 5 Pending invastigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28a. Placa of Injury - At homa, ferm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 29a. Certifier Certifying Physician: To the best of my knowledga, deeth occurred at the time, dete and place, end due to the causa(s) and mannar as stated.

2 Medicat Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) edical (Check only one)

30. Name and addrass of person who completed causa of daath (Itam 23a) (Type, Print) MD 4 secca 100 31. Data filed (Month, Day, Yaar)

OCT 1 8 2000

29b. Signature and title of certifie

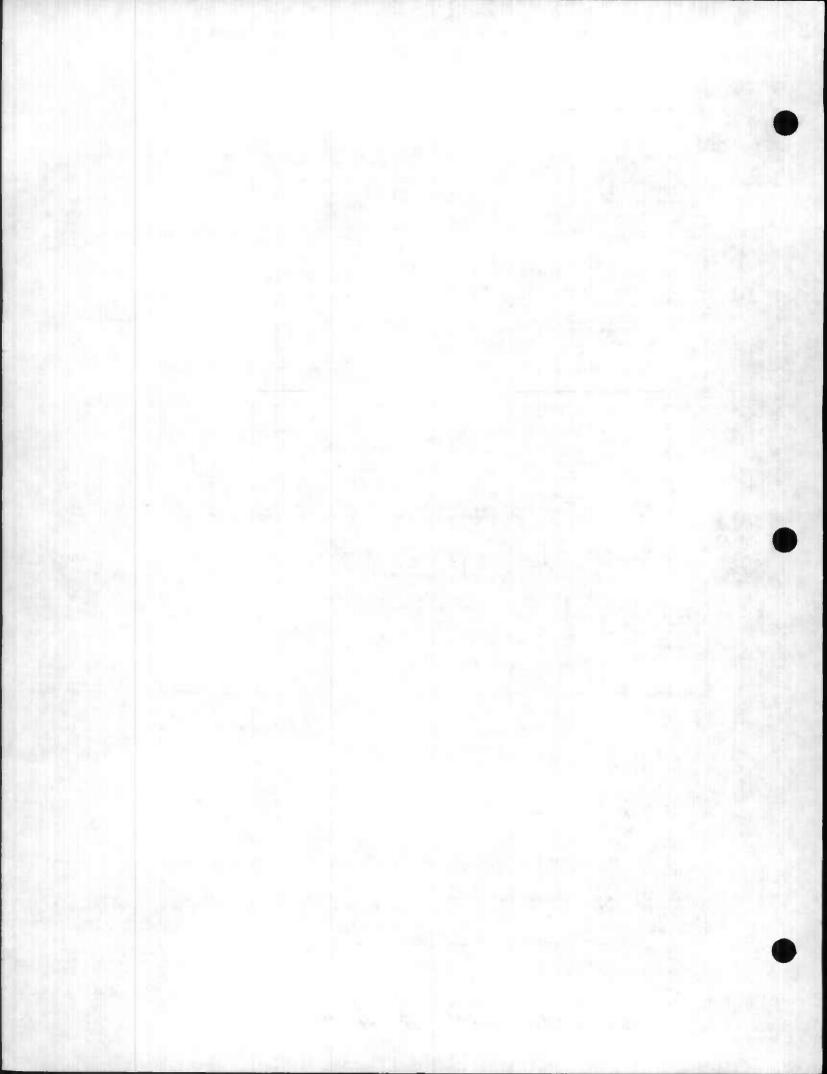
32. Registrar's Signetura

and menner statad.

29c. Licansa number

29d. Data signed (Month, Dey, Year)

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Deeth Day Year MINNICK MINNIE 14 2000 October

**Physician** /Medical Examiner

4e Facility Neme (If not institution, give street and number) HARBOR HOSPITAL CENTER 7. Age (In yrs. last birthday) 75 Yrs.

1 □ M 2 1 F

4h City Town or Location of Death BALTIMORE

23.05

**Funeral** Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Director

Funeral

Aq

Completed

Be

with the Maryland

filed within 72 hours after

. Pages 1 and 2 should be fil ment of Health and Mental H lant: If item 27 le marked off lury or other treumatic even

Department of Important: If eny injury or page.

**Physician** /Medical

Examiner

The law requires that the death certificate be executed

Box 68760,

P.O.

Records,

Division of Vital or Attending Physicien: Examiner

Physician/Medical

by

Completed

Be

Medical Certification: To

USB

200

After

after death.

in by

Baltimore, Maryland 21215-0020

5. Social Security Number 218-18-8746

10b. County Baltimore If Under 1 Year | If Under 24 Hrs. Days

8. Deta of Birth (Month, Day, Year) Birthplace (State or Foreign Country) MArch 141925 MAryland

Usual Residence of Decedent 10a. Stete

VIRGINIA

10c. City, Town or Location

Essex

10d. Inside City Limits 1 Yes 2 No

10e. Street and Number

21221

10g. Citizen of What Country? USA

4c. County of Death

1416 Sussex Road

11. Merital Status 1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No

 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2☐ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

10f Zin Code

16b. Kind of Businass/Industry

12th

17. Father's Neme (First, Middle, Last)

18. Mother's Name (First, Middle, Meiden Sumame)

Plasta Craft

Charles Eckles

19a. Informent's Neme/Reletionship (Type, Print)

Dorothy Heck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

Robert N. Minnick /husband

1416 Sussex Road

Business Owner

Baltimore MD 21221

20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State

20b. Place of Disposition (Nama of cametary, crematory or other place) Parkwood Cemetery 10/18/2000

20c. Location - City or Town, Stete

Balitmore

4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signeture of Funerel Service Licansee

23a. Pert1. Enter the disease, or confilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only he cause on each line.

22. Name and Address of Fecility
Connelly Funeral Home of Essex

300 MAce AVe. Baltimore Md. 21221

Immediate Cause (Final

CANCER OF LUNG

Approximate Intarval Between Onset and Death o years

disease or condition resulting in deeth)

Due to (or as e consequence of)

CRONIC OBSTRUCTIVE LUNG DISEASE

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Lest

Dua to (or es e consequence of): RESPIRATORY FAILURE Due to (or es e consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23h. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Wera autopsy findings available prior to completion of cause of death?

1 Yas 2 No 26. Place of Death (Check only one)

1 Yes 2 No

25. Was casa raferred to medical axaminer? 1 Yas 2 No

27. Manner of Deeth

1 Neturel

2 Accident

3 Sulcide

4 Homicide

5 Pending investigation

6 Could not be determined

28e. Dete of Injury (Month, Day Year) 28b. Time of

28e. Pleca of Injury - At home, term, street, factory, office building, atc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work?

28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Phyelcian: To the bast of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier Dy. THOMAS · NEDUMTHOTT 29c. License number ATHIL

RES 000

BALTIMORE

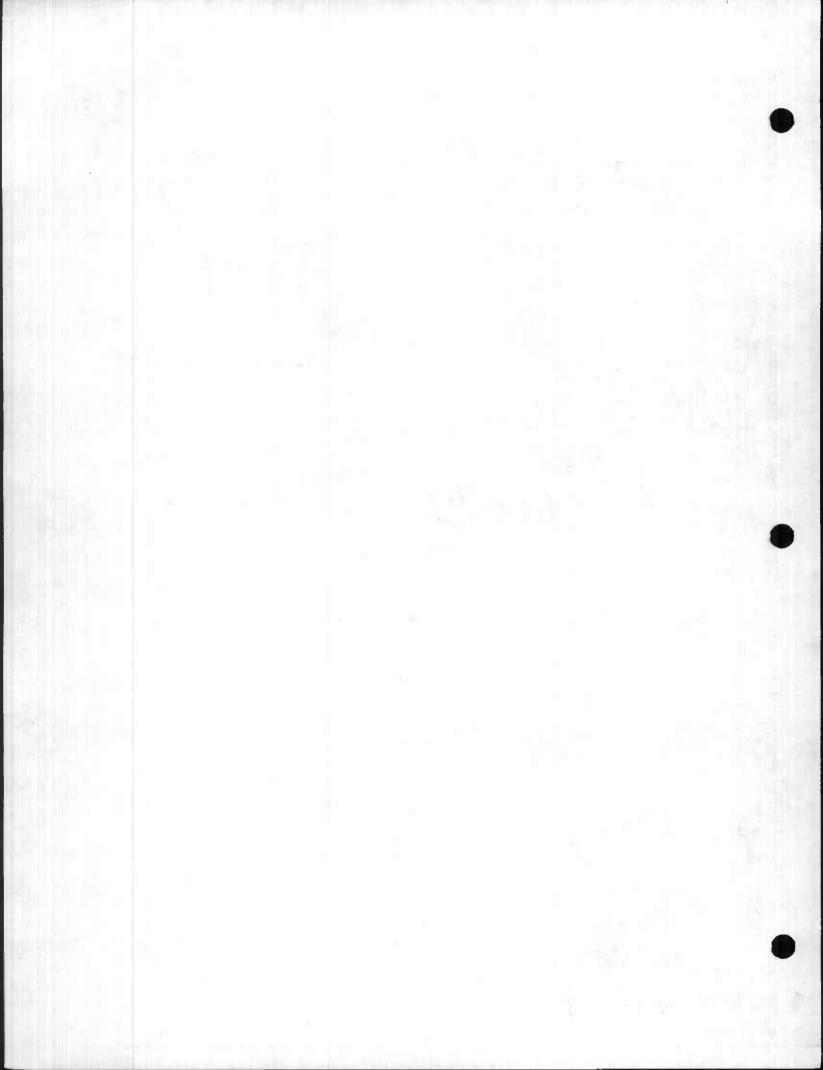
29d. Date signed (Month, Day, Year) October 14 2000

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

SOUTH 3001 31. Deta filed (Month, Dey, Year)
OCT 1 8 2000

HANOVER 32. Registrer's Signeture

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** CHARLES JOHN 16, 2000 October 11:15 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Long Green Center-Genesis Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)
June 20, 1907 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Months Hours 220-11-8065 1 X M 2 ☐ F 93 Yrs. Director England Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Director Maryland Baltimore 1 ☐ Yes 2 No **Brooklandville** 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 827 Hillside Road 21022 England death , Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mentel Hygiene. Important: if Item 27 Is marked other than "natural", or then eny Injury or other treumatic avent, the Medical Estimate page. 1 Yes 2 No
If Yes, Give
Year or Detes: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 years College (1-4or 5+) Manager Lumber 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Charles Nathan Nixon Ann Ley Ede 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 827 Hillside Road Brooklandville, Maryland 21022 Dorothy Nixon (wife) 20b. Place of Disposition (Name of 20a. Method of Disposition Dete 20c. Location - City or Town, Stete cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 10-18-00 Baltimore, Maryland 21. Signature of Funerel Service Licenses 22. Name end Address of Fecility Mitchell-Wiedefeld Funeral Home, Inc. reen 6500 York Road 21212 ien Baltimore, Maryland an 23a. Pert1. Enter the dispese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Finel month disease or condition resulting in death) Examiner Examiner ultintarct ears physician and s the buriel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): signed by the end by the detached to P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were eutopsy lindings available prior to 24a. Wes an eutopsy performed? Completed completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 48-Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 KNo edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funerai 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? After 1 Natural 5 Pending investigation ne Hospital or Attanding in 24 hours after death. The Funeral Director: After pletaly filled in by the fur 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, Ierm, street, Iectory, office building, etc. (Specify) 4 ☐ Homicide To the H.
Fe the Funa
Templately filt Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29b. Signature and file of certifie 29c. License number 29d. Date signed (Month, Day, Year) D17118 Dut 17, 2000 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

ORIGINAL

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SchWARTZM.D.

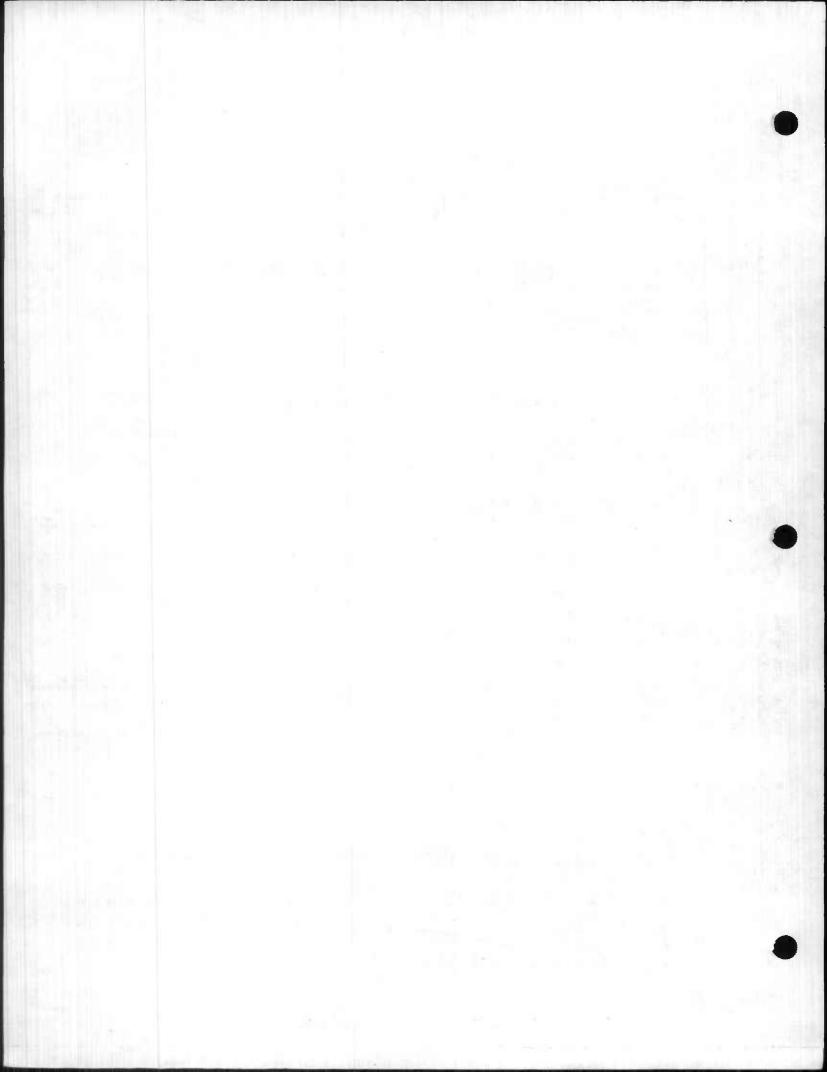
8 2000

32. Registrer's Signeture

aul

31. Date filed (Month, Day, Year)

OCT 1



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 29c, perFR, 11/21/00dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9 2000 6:00 P.M. Gladys B. Nash /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** | Capte 2
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y 12 24 Capitol Heights Prince Georges 517 Opus Avenue Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year) Months 1□ M 2□MF Yrs. 1930 69 Georgia Director 577-50-3417 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Directo Maryland Prince Georges Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23s or edical Examiner must be r U.S.A. 20743 517 Opus Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes = 22 No tf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2IX Married 1 Yes 2 KNo Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced the Medical Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondery (0-12) 12th College (1-4or 5+) Food Service Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) . Pages 1 and 2 should be fill thent of Health and Mental High tach: If Hem 27 is marked oth dury or other traumatic even Be Isaiah Barksdale Hattie D, Wynn 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles Nash/ Husband 517 Opus Avenue Capitol Heights, MD. 20743 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Importants if the Ingulniumy or of 1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 9/12/2000 Brentwood, MD. 22. Name and Address of Facility Latney Funeral Home cc0348 Part1. Enter the disease, of complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final disease or condition resulting In deeth) Breast Mass Examiner Due to (or as a consequence of) Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Hypertension Physician/Medical Due to (or as a consequence of): Ses Hyper Cholesterolemia 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of ceuse of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No director. Be 25. Was cese reterred to medice! examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2€No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 ☐ Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and menner as stated. edical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

physician end s the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending p for use as ed by the a signed t should I certificate hes b or Attending Physician: this death. Director: A after 24 hours after Funeral Dire Hospital To the

The Maryla

72 hours after

filed within

Hygiene.

Baltimore, Maryland 21215-0020

State

29b. Signature and

31. Date filed (Month, Day,

Registrar

30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) Allen S. Rogers MD

mw

Kaiser Permanente 1011 North Capitol St. N.E. Wash. D.C. 20002 32. Registrar's Signature

oaks

29c. License number

<del>1906</del>

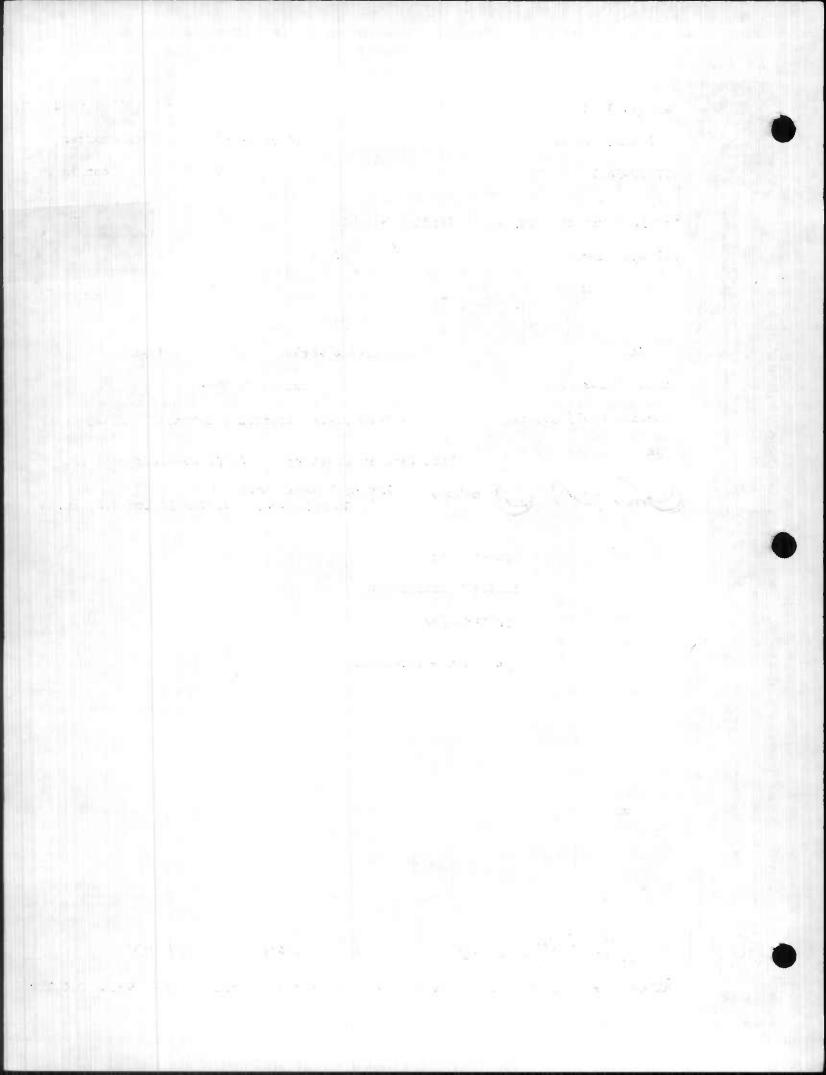
D0041881

29d. Dete signed (Month, Day, Year)

Geneva 0 6 2000

**DHMH 16 Rev 6/95** 

OCT



#### Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** William P. Neighoff 12 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Deat Facility Name (If not institution, give street and number) Examiner 8. Data of Birth (Month, Dev. Yeer) 5. Sociel Security Number 7. Age (In yrs. last birthdey) **Funeral** Months Days Hours Min. 120 M 2□ F Yrs. 79 214-12-1596 Director Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location r 28a-f show Director MD. Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or U.S.A. 0- 14. Race - Amarican Indian, Funeral 611 Riverside Dr. 21122 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No It Yas, Give Yaar or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: 1942-Specify: þ 3 Widowed 4 Divorced 1945 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) Completed be filed within 72 ha tal Hygiene. I other than "natur 15. Decedent's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 0 Carpenter & Maintanence A.A. County Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Peges 1 end 2 should be nent of Heelth and Mental William P. Neighoff, Sr. Sarah Fefel 19a. tntorment's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Important: If item 27 la any injury or other trau Mary T. Neighoff (Wife) 611 Riverside Dr. Pasadena, MD. 21122 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 10-16-00 Glen Burnie, MD. 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Rd. Pasadena, MD. 21122 23a. Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. **Physician** /Medical Immediate Cause (Final apric disaasa or condition resulting in death) Examiner Due to (or as e consequence of) Examine Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or as a consequence ot):

Piease Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene \(\)

physician and s the burial-trans 68760 Box P.O.

Records.

of Vital

Division

Physician/Medical signed by P Completed Be To edical Certification: if or Attending P. after death. Director:

Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Was an autopsy performed?

24b. Were autopsy tindings available prior to completion of ceuse of death?

Approximate Interval Between Onset and Death

3. Time of Death

9. Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

Maryland

Bleck, White, etc.

White

2 No 1 Yes

2 No 1 ☐ Yes

25. Wes case reterred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA

Due to (or as a consequence ot)

27. Manner of Death Natural 2 Accident 5 Pending investigation

3 Suicida

4 ☐ Homicide

that initieted events resulting in death) Last

6 Could not be determined

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No 28d. Describe how injury occurred 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier

16 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature and title of contil

29c. Licansa number

29d. Data signad (Month, Dav. Year)

13 WRMIF, mD 2106

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print) ROM

0 31. Date tiled (Month, Day, Yeer) 32. Registral's Signature

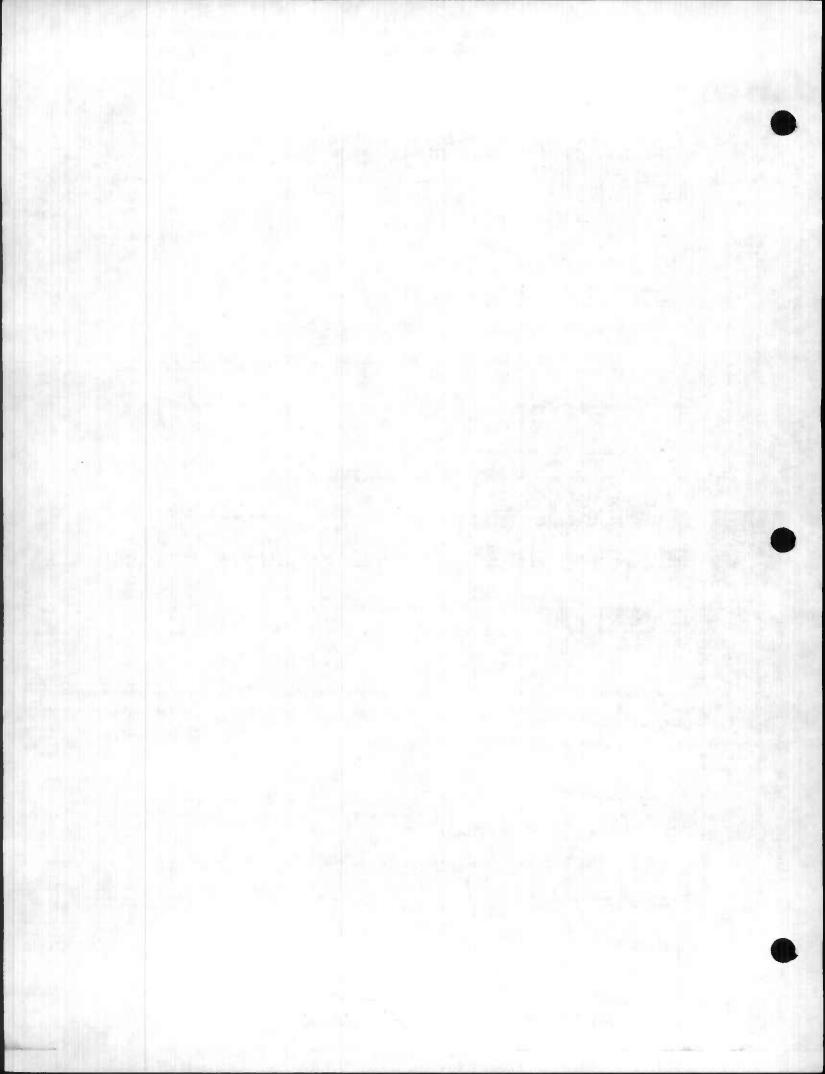
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Registrar DHMH 16 Rev 6/95

State

Funeral

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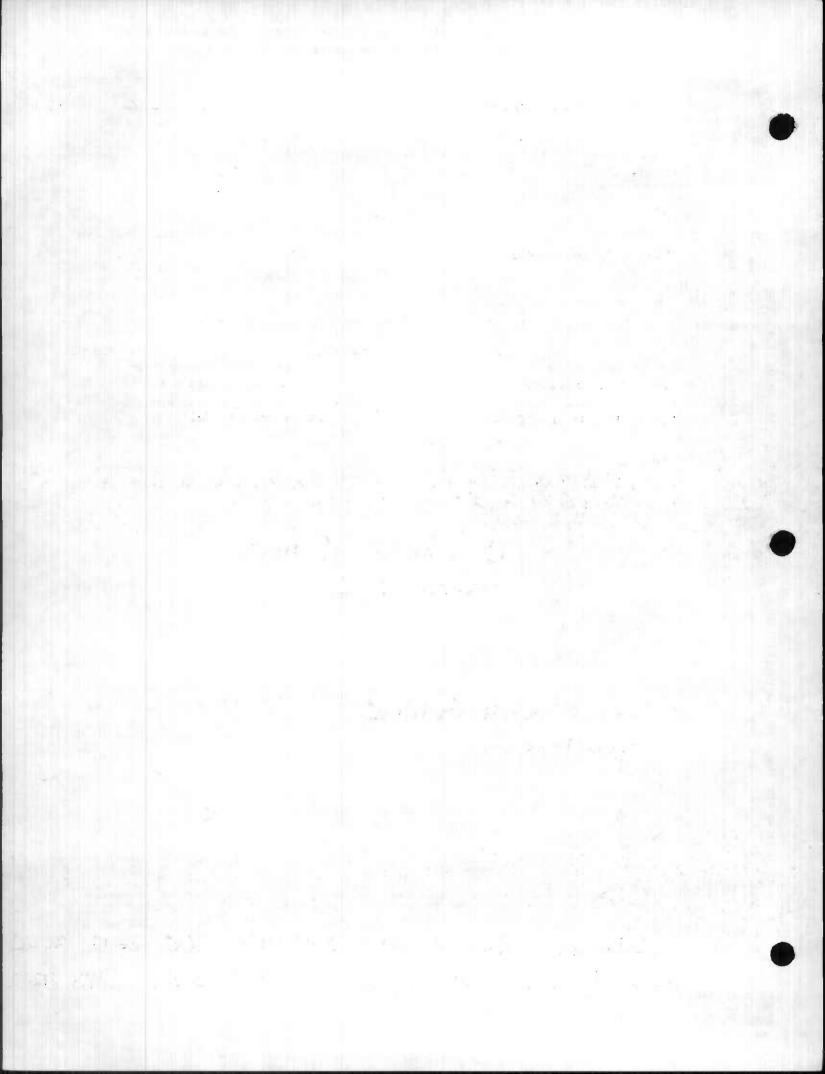
State of Maryland / Department of Health and Mental Hygiene

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-	_		Britan	100	- 6	

				Cer	tificate	of D	eath		F	Reg. No.		
	1. Decedent's Name (First, Midd	fle, Last)			No.				2. Dete of Dee		Vace	3. Time of Death
Physician	EMMA JANE	PATTERSO	N						OCTOBER	6, 200	Yeer )	10:45 PM
/Medical Examiner	4e Fecility Neme (If not institution		um <i>ber)</i>			4b.			cation of Deeth	4c. Count		
	523 N. Fulton				If Under 1 Y	(non T	Bali If Under 2	timo				
Funeral Director	5. Sociel Security Number 216-24-1993 Usuei Residence of Decedent	6. Sex 1	7. Age (In yrs. lest t	Yrs.		eys	Hours	Min.	8. Dete of Birth (Month, De) Mar 26,	, Year) 1926	9. Birthi	olece (Stete or Foreign http)  MD
land land	10e. State 10b. Count	у	10c. City, To									Od. Inside City Limits
Ba-f st	MD			Balt	imore							1 N Yes 2 No
ifer death with the Mei r terms 23s or 28s-f si where main be notified Funeral Director	10e. Street end Number 523 N. Fulton	Avenue			10f. Zip Co		1223			10g. Citizen of L	Whet Coul	ntry?
72 hours effer death with the Meryland natural; or thems 23s or 28s-f show acel Examiner must be notified at each for the property of the prop	11. Merital Stetus  1 Never Married 2 Ma  3 Widowed 4 Divorce	rried Armed F	2 ∰ No Bive		Ves Decedent Yes, specify			gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	Ble	ce - Americock, White,	etc.
tural's		d Yeer or		Se Deced	ent's Usuei O	ccupeti	ion			16b. Kind of 8	Rusiness/In	dustry
c • @ -	(Specify only high	est grede completed	1)	(Give I	kind of work of	one du	ring most	of worki	ing	TOD. Raid Of C	703111033411	Costry
filed within 72 ho Hygiene. Ather than "natura ant, or Wed call ant. or Wed call	Elementery/Secondary (0-12)	College	(1-4or 5+)		domest	ic				hou	sec1	eaning
Se se E	17. Fether's Neme (First, Middle	, Last)				1	8. Mothe	r's Neme	(First, Middle,	Melden Suma	me)	
Men Men To	Robert J. Esk	ridge					E.	lisa	A. Jac	kson		
nd 2 shilth and 27 is m	19e. Informent's Neme/Reletion Spring Ferguso				-				ue Bal			21223
Pages 1 and and of the sunt If Nem arry or other	20e. Method of Disposition  1		come		sition (Neme netory or othe		)	1	Dete	20c. Location	- City or T	own, Stete
Depart Imports any inj anse	21. Signature of guneral Service Ronald	S. Wade,	Director		Neme end A tate A Baltimo			Boar 212		W. Balt	imor	e Street
ing physician and se as the burial-transit	Immediate Cause (Finel disease or condition resulting in death)  Sequentially list conditions, if ery, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	e	Due to (or es of Due to	e consequence	uence of):		111	ren				
tten or us	Part II. Other significant conditi	lons contributing to	death but not resulting	j in the ur	nderlying caus	e given	in Pert I.		23b. Dld 1	obacco uss c	ontributa t	o the cause of death
that the dended by the a detected by Physic	Chronic	reno	il fail	ure	2				10	Yss 2000	3 □ Pro	bably 4 Unknow
The law requires that sate has been signed be page 2 should be determined.	Hypert	ension	n							an eutopsy rmed?	e e	fere eutopsy findings reliable prior to empietion of ceuse deeth?
The law ate hes page 2									101	res al No	1	Yes No
certificate rector, pag	25. Was cese referred to medic	9i					26. Place	of Deetl	h (Check only o	ne)		
S die	1 Yes 2 No	Hospital:	Inpatient 2 ER/	Outpatien	t 3D DOA	Other	: 4□ Nu	rsing Ho	me 5 Aesid	tence 6 🗆 Ot	ther (Speci	fy)
Attending Ph octor: After th by the funeral	27. Menner of Deeth  1 Naturel 5 Pendinvest 2 Accident invest	ing (Mo	e of Injury 28t onth, Day Year)	o. Time of Injury	28c.	Injury e Work? 1 \( \text{Ye}	es 2 🗆 I		28d. Describe I	now injury occu	irred	
- 2 - T	3 ☐ Suicide 6 ☐ Couid	mined   286, Ple	ce of Injury - At home, ding, etc. (Specify)	farm, stre	eet, fectory, o	ffica			28f. Location (5 City or Tov		ber or Rui	al Route Number,
Hospi 14 hour Funer tely fil		Examiner: On the	ne best of my knowled basis of examinetion onner steted.									
To the comple	29b. Signeture and title of certification	4 A.Z	meh	mo	29c. L	S L	number	96		29d. Dete sign		
	30. Name and address of person	who completed car	301 51	e) (Type	Print)	Su	ite	90-	7 B	altin	oner	2, 2000 ND 2120

DHMH 16 Rav 6/95

Registrar



#### Please Type or Print in Black indelible ink. Assure All Copies Are Legible. 945 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, 2. Data of Death 3. Time of Death Month Dev 2000 CX 0 Tom 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Age (In yrs. last birthdey) 5. Sociel Security Number 6. Sex 9. Birthplece (State or Foreign Days 1XM 20 F 212-30 -9514 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. Wes Dededen Armed Forces 11. Marital Stetus lent Ever in U.S. 1 Never Married 2 Married 1 Yes 2 No 1□ Yes 2 No Specify: Specify: () 3 Widowed 4 Divorcad Yeer or Detes: 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grede complated) Elamantary/Secondary (0-12) Cottega (1-4or 5+) 4 17. Father's Neme (First, Middle, Last) other's Neme (First, Middle, Meiden Sumeme) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, 19e. Informent's Name/Reletionship (Type, Print) 280 Kete 20b. Plece of Disposition (Nama of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) HOY 21. Signature of Edneral Service Lice 22. Name end Address of Fecility Vans or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, List only one cause on each line. Baltimore 21234 Immediate Causa (Final ischemic 72 years cardion diseesa or condition resulting in deeth) COLOMONA Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest hypercholesterolenia Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Wara autopsy findings eveitable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axeminar? 26. Pleca of Death (Check only ona) Othar: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 2 X ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death Dete of Injury (Month, Dey Year) 28b. Tima of Injury 28c. Injury et Work? 28d. Describe how injury occurred

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

**Examiner** 

**Funeral Director** 

þ

Completed

Be 2

**Funeral** 

Director

Department of Health and Mental Hygiene, insturel, or Nems 23s or 28s-f show important: if Nem 27 is marked other than "naturel", or Nems 25s or 28s-f show any injury or other traumatic event, are Medical Examiner must be notified at any injury or other traumatic event, are Medical Examiner.

Peges 1 and 2 should be filed within 72 hours efter death with

Baltimore, Maryland 21215-0020

the Marylend

Physician/Medical Examiner ettending physician end for use as the bunel-transit signed by the e p Completed peed

The law requires that the death certificate be executed

Hospital or Attending Physician:

NO FEB

death.

Division of Vital Records, P.O. Box 68760

page 2 s ils certificate i director, page Be 2 this funeral Certification: Affer within 24 hours after death To the Funeral Director: completely filled in by the

> State Registrar

Medical

29b. Signeture and title of capifier

5 Pending investigation

6 Could not be determined

1 Naturel 2 Accident

3 Suicide

29a. Certifier

4 Homicide

1 Certifying Physician: To the bast of my knowledga, daath occurred et the time, date end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of axamination end/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end manner stated. 29c. License number

1 Yes

2 No

29d. Dete signed (Month, Dey, Year)

Suite 201 Baltimore

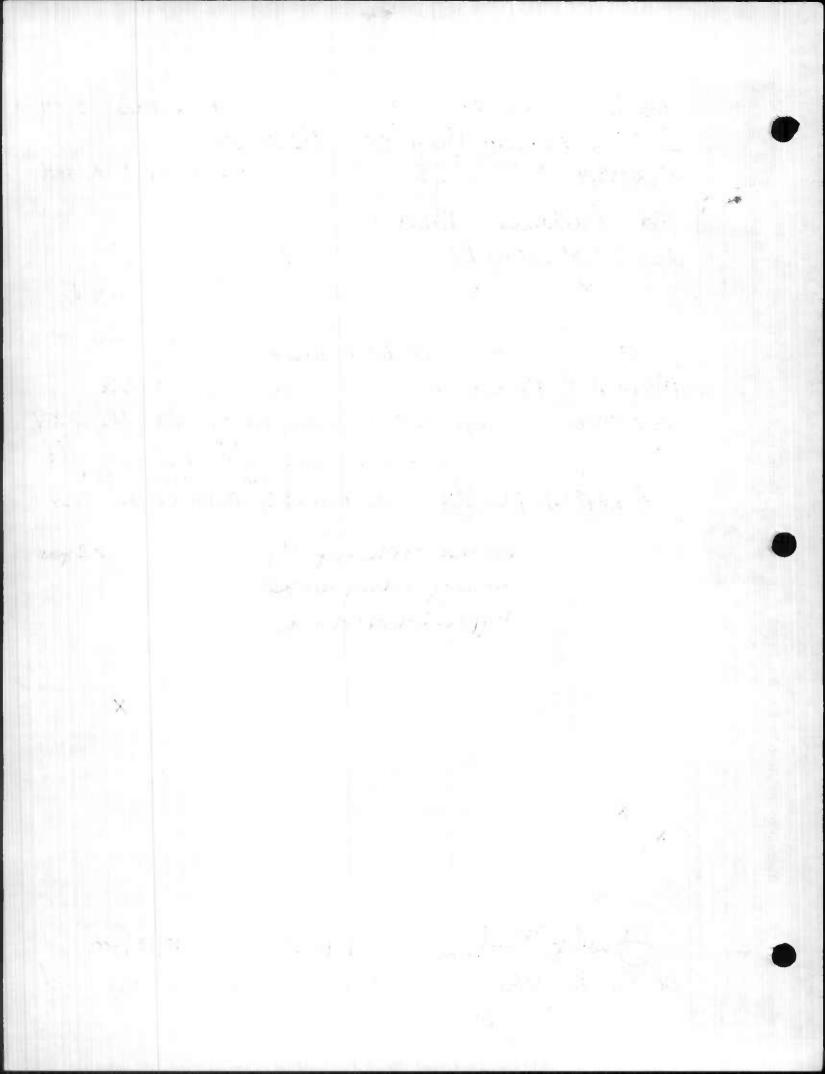
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

30 Name end rson who completed cause of deeth (Item 23e) (Type, Print)

KROKO 31. Deta filed (Month, Day, Year) 32. Registrer's Signeture 8

2000

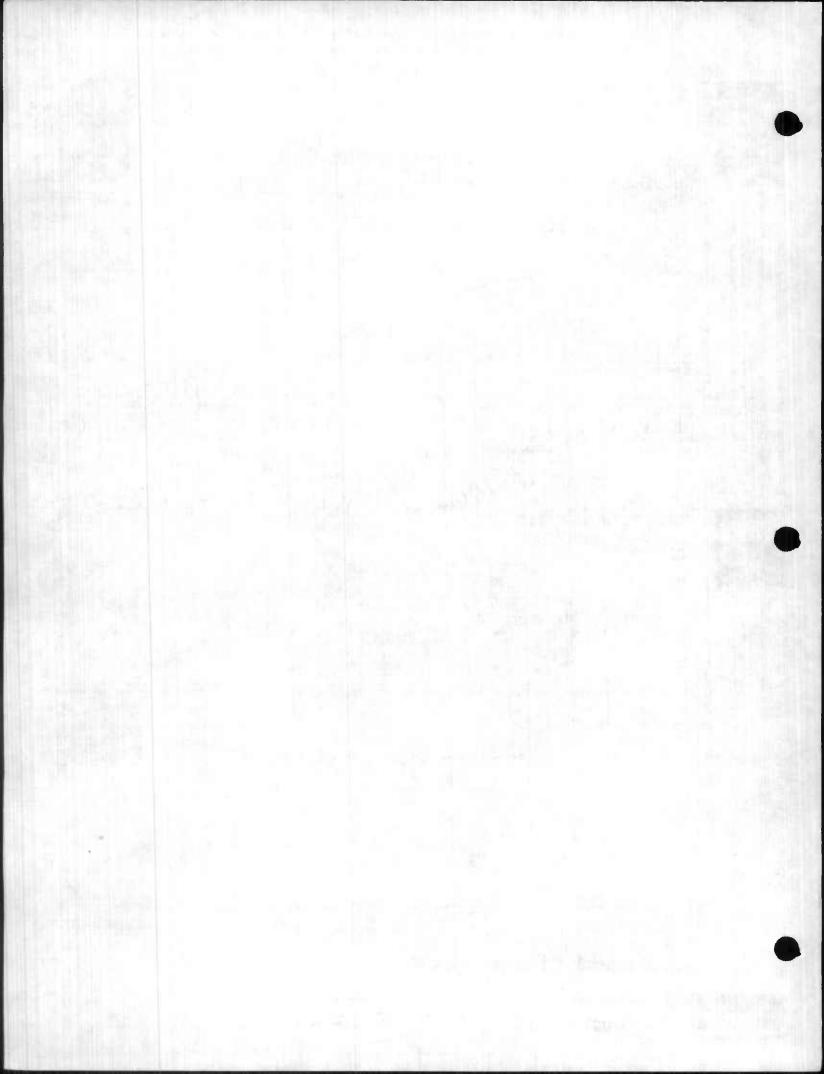
28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene 00 32016

		Certificate of Death	Reg. No.	32340
Physician	Decedent's Name (First, Middla, Last)	2	2. Date of Death Month Dey Year	
/Medical Examiner	MARV) N  4a Facility Name (ff not institution, give street end number),	PATTERSON 4b. City, Town, or L	OCTOBER 14 200 ocation of Death   4c County of De	
Examiner	Bon Secours H	ospital Balti	more N	IA
Funeral Director	5. Social Security Number 6. Sex 17 - 62 - 1899 19 M 2 F 7. Age 19 Usual Residence of Decedent	e (In yrs: lest birthday) If Under 1 Yaar If Under 24 Hrs.  Yrs. Months Deys Hours Min.	8. Dete of Birth (Month, Pey, Year) April 27,1954 N	inhpleca (Stele or Foreign Jountry)
yland	10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
the Marylar 28a-1 show notflied at	Maryland N/A	Baltimore	10a China ad Mina d	1 Yes 2 No
th with 23a or and Die	2409 Baker St	10f. Zip Code 2/2/6	10g. Citizen of What (	A
020 urs after Nr., or the		If Yas, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)  14. Haca - An Bleck, Wr	American  American
	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondary (0-12)  College (1-4or 5	16a. Decedent's Usual Occupation (Giva kind of work done during most of work iffe. DO NOT use retired)  Heavy Equipment D	16b. Kind of Busines	struction
Baltimore, Maryland 212. permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Media.  To Be Comp	17. Father's Nema (First, Middle, Last)	18. Mother's Nen	ne (First, Middle, Maiden Surneme)	son
Mary 12 shou h and N is mar reumal	19e. Informant's Name/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Ru	ral Route Number, City or Town, Stete	, Zip Code)
ges 1 and to death if Ham 2	20a. Method of Disposition  1 Buriel 2 Cremetion 3 Removal from State	20b. Plece of Disposition (Name of carpetery, crematory or other pleca)	Deyb 20c. Location - City of	or Town, Stete
Baltimore, permit. Pages 1 ar popartment of Hea important: if item; any injury or other once.	4 Donation 5 Other (Specify)  21. Signatora of Funeral Service Alcansee	22 Name and Address of Facility	Funeral Ham	wne, Ma.
m 50539	23a. Peny Enter the diffesse, or complications that causad	I tha death. Do not antar the mode of dying, such as cardiacine.	Ave Batto, M. cor respiretory arrest,	d. 21216 Approximete
Priysician /Medical	Immediate Cause (Final	1 1 0		Intervel Between Onset and Death
Examiner	disease or condition resulting in deeth)	Due to (or as a consequence of):		
niner	b. Human	· Immunodficiency Sy	ndme	
68760, icate be executed physician and s the bunk-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or es a consequence of)		
68760, rificate be execu ng physician and as the burial-trai		Dua to (or as a consequence of):		
T. 2 2 3 5	d			1
O. B ne death the atte thed for ysicia	Pert it. Other significant conditions contributing to death but	ut not resulting in the underlying cause given in Pert I.	23b. Did tobacco use contribu	ite to the cause of death?
Is, P.O. BOX as that the death certi igned by the attending be detached for use a by Physician/M	Malnutrition . Carlesia		1  Yes 2 No 3 □	Probably 4 Unknown
Division of Vital Records, P.O. Box in Attending Physician: The law requires that the death centre death.  Director: After this certificate has been signed by the attendit in by the funeral director, page 2 should be detached for use extification: To Be Completed by Physician/			24a. Was en eutopsy performed?	b. Were autopsy findings available prior to complation of cause of death?
The law rate has page 2			1 ☐ Yes 2 ₺ No	1 Yes 2 No
Of Vital F Physician: The Physician: The rithis certificate mal director, pag 1: To Be Col	25. Wes case referred to medical examiner?	Other	eth (Check only one)	
Division of Vital Record To the Mospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should Medical Certification: To Be Completed	1		lome 5 ☐ Residenca 6 ☐ Other (S)  28d. Describe how injury occurred	рөспу)
Division c the Hospital or Attending Pl thin 24 hours after death. I we Funeral Director: After the mpletely filled in by the funeral Medical Certification:	e Could not be	ury - At home, ferm, street, fectory, offica c. (Specify)	28f. Location (Street end Number or City or Town, State)	Rural Route Number,
To the Hospital or within 24 hours aft To the Funeral Dir completely filled in Medical Cerr	29e. Certifier  (Check only one)  1 Certifying Physician: To the best of end menner steepens.	of my knowledge, deeth occurred et the time, date end plece examinetion end/or investigation, in my opinion, deeth occu sted.	, end due to the cause(s) and menner rred et the time, dete end pleca, and d	es stated. lue to the cause(s)
To the within To the comple	29b. Signature and title of compare of the compare	29c. License number	29d. Date signed (Mc	onth, Dey, Year)
	20 Name and address Town	y 1 / > 2	1 10-1	9-2000 12-17
N	30. Name and address of person who completed cause of de DALSMAN. S. SAL-UJA	600 W. MOUNT ROYAL	Ave, Balto 21	1217
State Registrar	31. Dete filed (Month, Day, Year) - 32. Registra	he B Ina v		

ORIGINAL



# Baltimore, Maryland 21215-0020 pemit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avent, the Medical Exercipet must be notified at once.

Physicia /Medic Examin

Funeral Director

	LXa	i fini
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this cartificate has been signed by the attending physician and accompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /wedicar Examiner

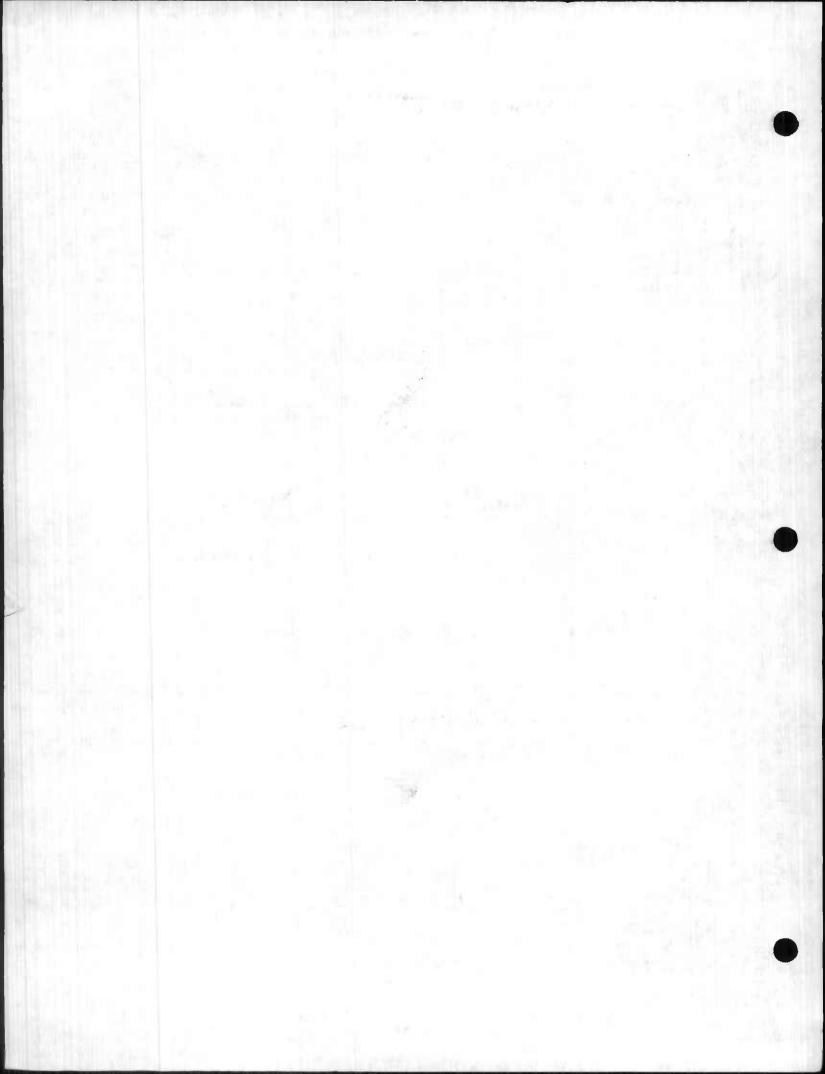
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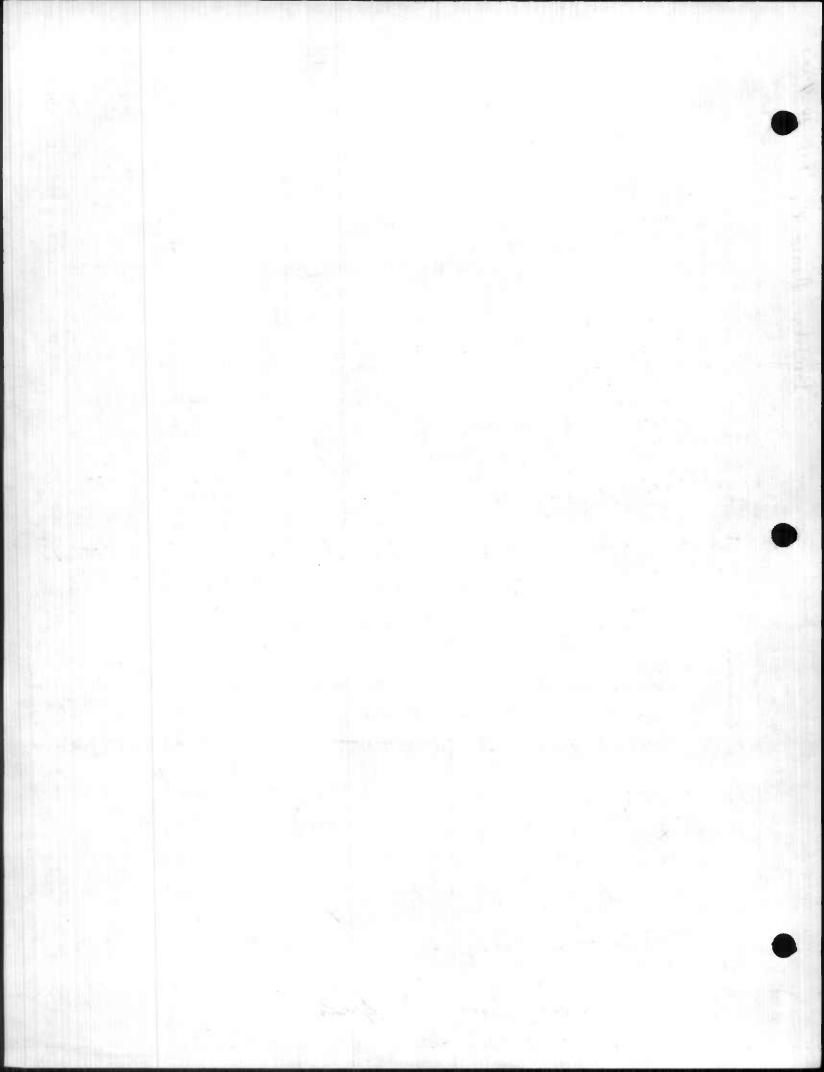
State of Maryland / Department of Health and Mental Hygiene 1 3 2 9 1. 7

					Cei	rtificat	e of	Death			Reg. No.	00 .	02041
	. Decedent'a Nam	e (First, Middle, La	ist)							2. Date of De	ath Day	Year	3. Tima of Death
	John Edw	ard Pink	erton, Sr.	10						10/11/	2000		10:13pm
	a Facility Name (I	f not institution, giv	re street end number)					4b. City, To	wn, or L	ocation of Deat	4c. C	ounty of Deat	h
			ons Nursin			1 17 11 1		Catons		-		ltimore	
5	. Social Security N 213-09-2			9 (In yrs. Ia 82	st birthday) Yrs.	Months	1 Yaar Days	If Under Hours	Min.	8. Date of Bir (Month, Da 06/25/	1918	9. Birti Co Mary	hplaca (Stete or Foraign untry) y Land
-	Jsual Rasidence of 0a. State	Decedenf 10b. County		10c City	Town or Lo	neation							10d. Inside City Limits
	UE. State	Anne Ar	undel		Burn								1 □ Yes 2√ No
	MD 0e. Street and Nur		under	OTCI	Durin		Code				10a Citiza	n of What Co	**
			le Apt.#	788		10f. Zip				23.71		ed Stat	
De completed by runeral priests	1. Marital Sfatus 1 Nevar Merri 3 Widowed	ed 2 Married 4 Divorced	12. Was Decedent 6 Armed Forces? 1 □ Yas 2 □ N If Yes, Give Year or Dates:			Was Dece if Yes, spe 1  Yes	cify Cuba	lispanic Or an, Mexica Specify:	n, Puarto	pecify Yes or No Rican, etc.)		Reca - Ame Black, White pecify:	
200	(Spec	15. Decedent'a E	ducation ade completed)		16a. Dece	kind of wo	rk done	during mos	t of work	king	16b. Kind	of Business/	Industry
	Elementary/Seco		College (1-4or 5			DO NOT u							
5	1	_			Machi	ne Me	char		1. 11.			d Produ	action
1	7. Father's Name	(FITS), MIGGIO, LASI	)					18. MOUN	ers Nam	e (First, Middle	, Maiden Si	итете)	
	John Henr						10.			ta Augu			
	19a. Informant'a Na Iohn Edwa		rton, Jr.							nal Route Numb horpe, ]			cip Code)
-	Oa. Method of Disg		reon, or.	20h Pi	ace of Dispo	-		C I IIC	1100	Data		ation - City or	Town State
-	1 Burial 2		Ramoval from Stafa	Ce	ro Cr	metory or o	other plan	ce)	1 .	10/12/0			
-	21. Signatura of Fy	naral Sarvica Lice	nsee	W.	22	2. Nama ar	nd Addre	ss of Facili	ty Aml	brose F	unera	1 Home	. Inc.
	off	MA	CHINES	200	1	328 S	ulph	ur St					yland 21227
	shock, or hea Immediate Cause ( disaase or condition resulting in death)	rt tallure. List <i>on</i> ly Final	polications that causad one cause on each lin e.	10.						fores		) ) ) (	Interval Between Onset and Daeth
Cyalling			b		1235								95
	Sequentially list co f any, leading to in cause. Enter Unde	rlying		Due to (or	as a consec	quence of):							
5 1	Cause (Disease or that initiated avents resulting in death) I		C	Due to (or	as a conseq	quence of):							
8		30	d									1	
Dy Filysiciany	One to		contributing to death bu			inderlying (	cause giv	en in Part			Yes 2		robably 4 Unknown
200	A	1 +	joint o							24a. Wes	en autops		Were autopsy findings available prior to
Paradimon	TAO	shou	concer							, ,			completion of cause of death?
3	- 111									10		No	1 Yes 2 No
3	25. Was case refer examiner?		Hospitel:				Ott			th (Check only		Tau.	
2	1 ☐ Yea 2 🔀		1 ☐ Inpatie		R/Outpatle 28b. Time o		UA.	4 DIN	ursing H	ome 5 Res			ocity)
	1 ANatural 2 Accident	5 Pending investigation	(Month, Day	Year)	Injury	М	28c. Injui Wo 1 □	rk?  Yes 2□	No.	EUG. Describe	now injury	00001100	
	3 ☐ Suicida 4 ☐ Homicide	6 Could not be determined		ury - At hor c. (Specify,	me, farm, at	reet, factor	y, office				(Street end wn, Stete)	Number or R	urel Route Number,
	29a. Certifier (Check only one)		hysician: To the best of miner: On the basis of and manner ata	axaminati									
2	29b. Signature and	title of cartifier	and manner ata			29	c. Licens	sa number		- 13.1	29d. Date	signed (Mont	th, Dey, Year)
	> M	Clelan	LMD				D-	60	521		Octo	bul	2,2000
) 3	0. Name and addr	ess of person who	completed cause of de	eath (Item	23a) (Type,	, Print)	784	5 0	gh	wood	Pan	ed Su	205 Th
2	31. Dete filed (Mon	-	32. Registra	ar'a Signat	ure		3	un	Du	mia,	NU	200	) (
		OCT 1 8		Market	w	6	100	uts:	7 5				

DHMH 16 Rev 6/95

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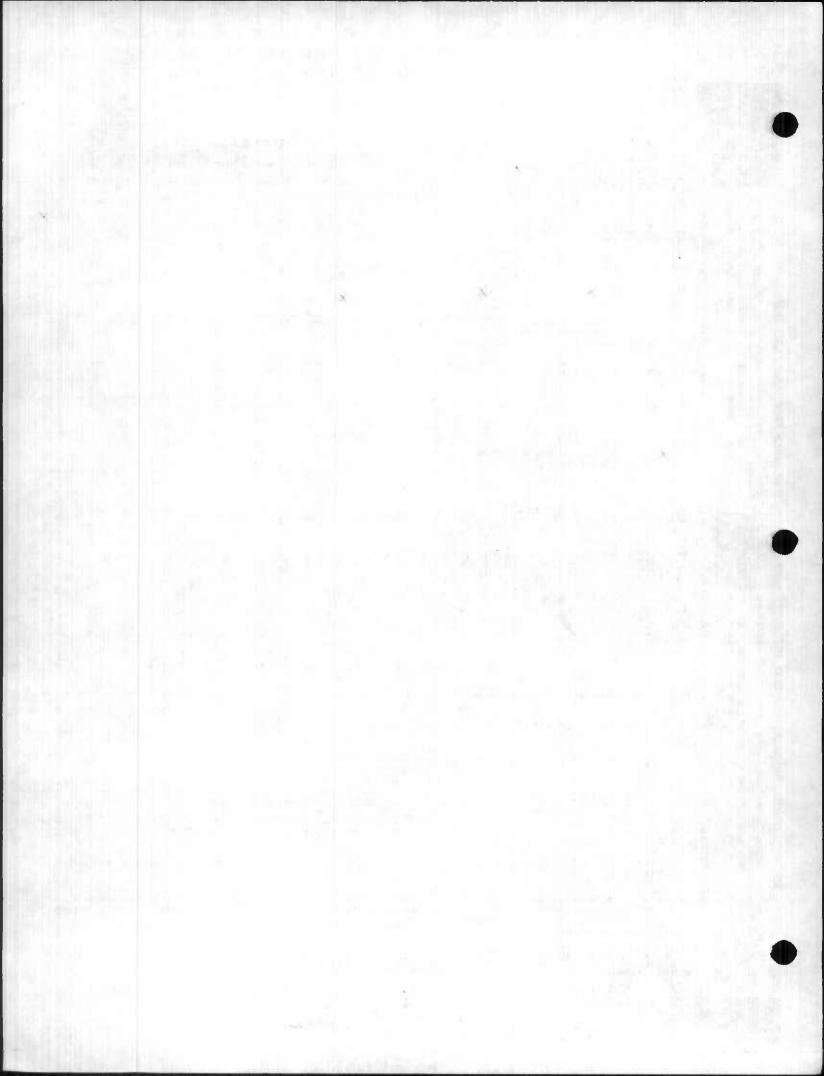




# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	1. Decedent's Neme (First, Middle, Las	1)	Cert	tificate of	Dealli	2. Date of De	Reg. No.	3. Time of
cian	Regina.	Reitz				Month	Dey 16	Yaar 3:4
lical iner	4e Facility Name II not Institution, giva	street and number)			4b. City, Town, or			of Death
	230 Comp	ass Rd			Bultir	nore		
l r	213-20-9030	7. Aga (In yrs.	last birthdey) Yrs.	If Under 1 Yaar Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Day May 1	th ay, Year) 1,1933	Birthplaca (State or Country)     Md.
	Usuel Residence of Decedent  10a. Stata 10b. County	10c, Cit	y, Town or Loc	cation				10d. Inside Cit
or	Md. Baltime		ssex					1 🗆 Yas
Directo	10e. Street and Number	510	JJCA	10f. Zip Code			10g. Citizen of W	/hat Country?
	230 Compass Rd	•		21220	0		USA	
by Funeral	11. Maritel Status  1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever In U Armad Forces? 1  Yes 2 No If Yes, Give Yeer or Detes:		Vas Decedent of H Yes, specify Cub	dispenic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No o Rican, atc.)		a - American Indian, k, Whita, etc. White
	15. Decedent's Edu (Specify only highest gred	ucation (e.completed)	16a. Decede	ent's Usuel Occup	pation during most of word)	tkina	16b. Kind of Bu	siness/Industry
Completed	Elementery/Secondary (0-12)	College (1-4or 5+)			d)	9		
3	12 yrs.		Bookk	eeper			Law Fi	
Be	17. Fether'a Neme (First, Middle, Last)	-1-2					, Meiden Sumem	6)
0	Albert Szambor:  19a. Informant's Neme/Reletionship (T.		10h Mallin	n Address (Ctanat	Mary I	Biedro		State Zin Cadal
	Joseph Reitz	husband						
	20e. Method of Disposition	20b. F	Place of Dispos	ition (Neme of	T	Dete		City or Town, State
	1 Burlal 2 Cramation 3 4 Doneticn 5 Other (Specify,	Ramoval from Stata St	Stani	slaus	ca)	oct 19 2000	Dundal	
	21. Signature of Funerel Service Licens		22.	Name end Addre	ess of Fecility			
	N htlan	C = 2	Co	nnelly	Funera.	L Homeo	of Dund	alk, P.A.
$\dashv$	23a. Perrii. Enter the disees or comp shock, or heert feilure.	lications that caused tha deal						1k, Md. 2
	shock, or heart feilure. Het only o	one ceuse on each line.						Onset and D
	Immediate Cause (Finel disease or condition	Henreto	00 00	01000	Carro	inam	2 .	! Im
	resulting in deeth)	Due to (c	or es e consequ	uence of):	Carci	A 101 1C	3	
		. cirrl	Losis	5				lone
I	Sequentially list conditions,	Due to (c	or es a consequ	uenca of):				
- 1	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Hepati	tis	C				304
3	that initieted events rasulting in death) Lest		r es e consequ	ience of):				
riysicialyme		· Blood	l tr	anst	wise	0 19	76015	307
				0				
	Pert II. Other significant conditions co	ntributing to deeth but not res	ulting in the un	iderlying cause give	ven in Pert I.			ortribute to the cause of
	Hypertens	m				1	Yee 2 200	3 Probably 4 1
	<b>)</b>						s an autopsy ormed?	24b. Were eutopay fi evaileble prior to completion of co of deeth?
1						10	Yes 2 No	1 ☐ Yes 😢
	25. Wes case reterred to medical				28. Plece of De		•	12.00
	examiner?	Hospitel: 1 inpatient 2	ER/Outpatient	3 DOA Ot	hor		idenca 6 DOth	ar (Specify)
	27. Menner of Death  1 Selatural 5 Pending	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju Wo			how injury occurr	
	2 Accidant Investigation				Yes 2□No			
	3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Special	ome, ferm, stre	et, fectory, office			(Street end Numb own, State)	er or Rurel Route Num
	29e. Certifier (Check only one) 1 Certifying Phy 2 Medical Example one)	sician: To the best of my kno iner: On the basis of exemine and menner steled.	wledge, deeth	occurred at the ti estigation, in my o	me, date and plece opinion, death occu	, end due to the irred et the time	ceuse(s) end me , date and place,	nner as atated. and dua to tha ceuse(s
D.	29b. Signatura and titla of certifiar			29c. Licens	sa number		29d. Dafa signer	d (Month, Day, Year)
							110	100 -
	Joneston	MM		DI	4-20		Octobe	DL 192 704
Medical	U	SWWD  ompleted cause of deeth (Iter	n 23a) (Type F	D C	16389		Octob	or 18,200
	U	ompleted cause of deeth (Iter	n 23a) (Type, F	Print)	16389 Backin	ine h	nD 213	02

**ORIGINAL** 



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 2. Date of Death 1. Decedent's Neme (First, Middle, Last) **Physician** 1130 AM Kice Jr. OCTOBER 2000 Bernard 13 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner HOSPITAL If Under 1 Year ALTIMORE If Under 24 Hrs. | 2 Po HOP JOHNS CIT 5. Social Security Number 7. Age (In yrs. last birthday) **Euneral** 560 Monfhs Deys Min. 1 M 2 F 62 216-Director Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10d. fnalde City Limits 10b. County Yes 2 No Funeral Director Maryland mor 10a. Street and Number 10f. Zip Code 10g. Cifizen of What Country? 2120 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stafus 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married 1□ Yes 2No Specify: Specify: Be Completed by 00 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) er 17. Father's Name (First, Middle, Last) 8. Mother's Neme (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic avant and. 19a. Informant'a Name/Relationship (Type, Print) (mother) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Md. 21202 2 0 20b. Plece of Disposition (Neme of cemetery, crematory or other place) City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from Stafe 4 Donation 5 Other (Specify) 20c. Location 18/2000 areenmount rematory 21. Signattre of Funeral Service License 22. Name end Address of Fecility Fune S Jose Joseph 2222 Bal Home 21216 W. North Ave. Approximate interval Between Onset end Death ter the durase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, heart fature. List only one cause on each line. **Physician** /Medical Immediate Cause (Final Distress Respirator disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Physician/Medical Examiner Pneumocystis no cystis premonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Immuno de ficiency vired Due to (or es e consequence of): Pert II. Other significant conditions confributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown iver þ 24b. Were eutopsy findings available prior to completion of cause of deeth? Be Completed 24a. Wes en autopsy Pencreatiti performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 5 Pending Investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be 3 Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) and manner as steted. 2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner ateted. 29a, Certifier

The law requires that the death certificate be executed and Box 68760. the attending physician P.O. funeral director, page 2 should be detached been signed by Division of Vital Records. this certificate has al or Attending Physician: The safter death.

In Director: After this certificated in by the funeral director, p. completely filled in by To the Hospital of within 24 hours a To the Funeral D

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0020

"natural", or items 23s or 28s-f show

than

other 1

traumatic awant, the Medical Examiner must be notified at

State Registrar

30. Name and address of person

who completed cause of death (Item 23a) (Type, Print) 600 32. Registrer's Signature

29d. Date signed (Month, Day, Year)

RES-000

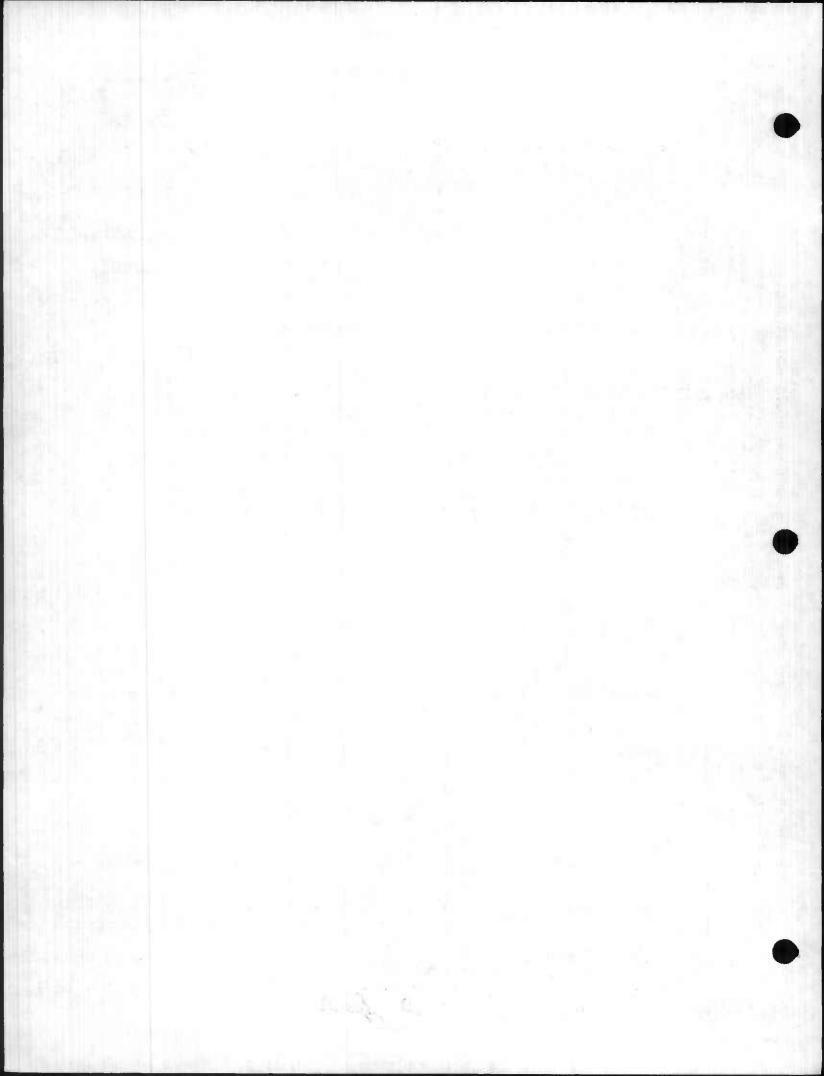
29c. License number

October 13. 2000

BALTIMORE MD STREET 21287

31. Date filed (Month

29b. Signeture and title of certifie



#### Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Defe of Death 120AM **Physician** Ctober ,2000 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Tal DI 7. Age (In yrs. last birthday) If Under 1 5. Social Security Number Birthpleca (State or Foreign Country) **Funeral** 19M 20F Months Deys Hours Min 219-26-977 Usual Residence of Decedent Yrs. Director 10a. Stefa 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ahon 1 Yas 2 No Director Jore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? s 1 and 2 should be filed within 72 hours after death with Health and Mental Hydiene. fem 27.1 is marked other than "natural", or items 23a or other traumatic event, its beginning manter and other traumatic event, its beginning manter. 2120 MIL by Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify BIACK 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) College (1-4or 5+) 17. Fether's Neme (First, Middle, Last) 18. Mother's Nema (First, Middle, Meiden Sumame) Be Joseph 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Beletlonship (Type, Print) Pages 1 and 2 s ment of Health an 20b. Place of Disposition (Name of cametery, cremetory or other place) Important: If Item 2: any injury or other pncs. Baltimore, 20a. Method of Disposition 1 Burlal 2 Ocremetion 3 Removal from Stete 20c. Location - City or Town, Stete Dete permit. Page Department o 4 Donetion 5 Other (Specify) remator and Addrass of Fecility allians that caused the deeth. Do not enfer the mode of dying, such as cardiac or raspiratory errest, cause on the line. Approximete Interval Batween Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (oi es e consequence of) Be Completed by Physician/Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events Due to (or es e consequence of): Box 68760. thet initieted events resulting in death) Lest Dua to (or es a consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown elding 1 Yes 2 No Division of Vital Records. 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24a. Was an autopsy 2 10 No 1 ☐ Yes 2 ☐ No 1 Yas Hospital or Attending Physician: 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No this 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 DiNeturel 5 Pending investigation To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fur 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) **₩** ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the ceuse(s) and menner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the ceuse(s) and mennar stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. Licensa number 175 3

State

DHMH 16 Rev 6/95

OCT 1 8 2000 Registrar 0

31. Date filed (Month, Dey, Year)

32. Registrar's Signeture

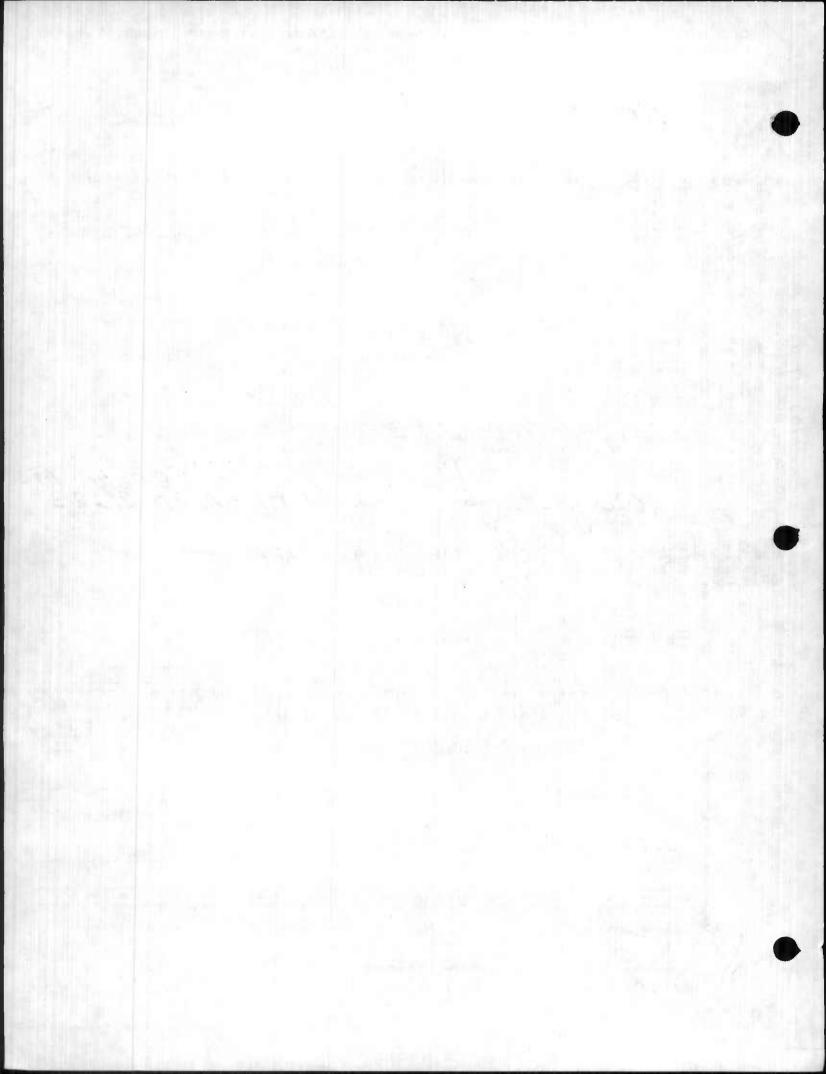
Mr.D.

Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print)

aluja

1600

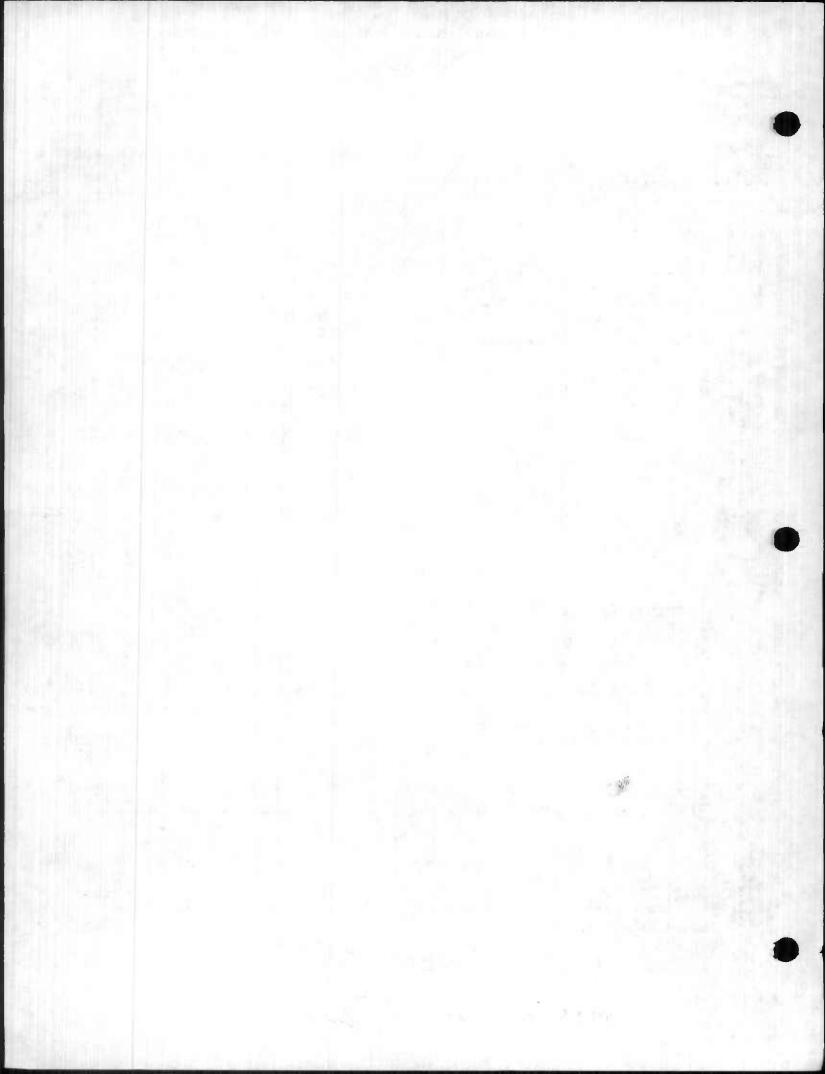
Ave. Bulto, md. 21217



# Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	Certificate of Dea	eath	Reg. No.	32932
Dissolution	1. Decedent's Name (First, Middle, Last)	2. Date o Month		3. Time of Deeth
Physician /Medical	Rhonda L. Robinson	Octob	her 16 20	500
Examiner		City, Town, or Location of D		
	330 Green Mountain Court	Pasadena	Anne Aru	indel Co.
Funeral	Months Days Ho	Under 24 Hrs. 8. Date of the lours Min. (Month	Birth 9. I	Birthplace (Stete or Foreign Country)
Director	216-96-5986 32 Yrs.			aryland
2 .	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
d at d				1 ☐ Yes 2 No
octo	MD. Anne Arundel Pasadena			
or 28a-fah be notified.	10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
	330 Green Mountain Ct. 21122		U.S.A.	
r tems 23 iner must Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispan If Yes, specify Cuban, Mo	inic Origin? (Specify Yes o Mexican, Puerto Rican, etc.	r No- 14. Race - A Black, W	merican Indian, hite, etc.
8 M		pecify:	Specify:	
Esa d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		W	nite
dica dica	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usuel Occupation (Give kind of work done during life. DO NOT use retired)	n ng most of working	16b. Kind of Busine	ss/Industry
or than 'natural, the Medical	Elementary/Secondary (0-12) College (1-4or 5+)			
CO HE	12 1 Admin. Tech.	Billion and the same and	U.S. Gov	
d off		. Mother's Name (First, Mi		
To To		Lillian Gray		
The man	19e. fnformant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and P	Number or Rural Route N	umber, City or Town, Stat	e, Zip Code)
12.0	Raymond T. Robinson (Husband) 330 Green Mour			
# f5	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City	or Town, State
10	1 \( \frac{\text{ZBurial}}{\text{ 2 \subseteq} \) Cremation 3 \subseteq Removal from State 4 \subseteq Donation 5 \subseteq Other (Specify) \)  Glen Haven Memorial	Park 10/21/	2000 Glen B	urnie, Md.
and a	21. Signature of Funeral Service Licenses / 22. Name and Address of	f Facility		
FEE		olyniak Fune		
	23a Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying su	tain Rd. Pas	adena, MD.	21122 Approximate
	23a Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause op each line.		.,	Intervat Between Onset end Death
sician edical	Immediate Cause (Final			2
niner	Immediate Cause (Final disease or condition resulting in death)  a. Carcinoma of Cercy			3 Y/3
<b>a</b>	Due to (or as a consequence of):			
tal-transit Examiner	b			
X X	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury			
burie B	cause, Enter Underlying Cause (Disease or Injury		fighter to	
as the burist-transit	thet initiated events resulting in death) Last Due to (or as a consequence of):			
	d.			
for use				
hed hed /	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in	n Part I. 23b.	Did tobacco use contrib	ute to the cause of death
Ph ate			1 Yes 2 No 3	Probably 4 Unknow
b d				
should should been s			Was an autopsy 24 performed?	lb. Were autopsy findings available prior to
10 N 10			2.	completion of cause of deeth?
Bege		Y Comment	1□ Yes 2MNo	1□Yes 21 No
Be Co	25. Wes case referred to medical 26.	6. Place of Death (Check of	only one)	
To Be	examiner?	4□ Nursing Home 5		Specify)
5 7	27. Menner of Deeth 28a. Date of Injury 28b. Time of 28c. Injury at		ribe how injury occurred	E-5-77
the funer cation		2 No		
	3 Suicide 6 Could not be	28f. Locat	ion (Street and Number o	r Rural Route Number,
Ta Ta	4 Homicide determined building, etc. (Specify)	City o	r Town, State)	
	29a. Certifier (Certifying Physician: To the best of my knowledge, death occurred at the time, de	date and place, and due to	the cause(a) and mars	r ac etalor
pletaly fill	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion			
Med med	A distribution of the control of the	ımher	29d. Date signed (M	lonth Clay Veer!
8				
11	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Win C WATERFUELD MD SHAMES Chica Cen	906	October 1	7, 2000
1/1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0 /	7 / 1	0, 21229
1	Un C WATERAVIELD MO SHIghes Concer Cen	ty 700 C	ator the A	Jellime MO
State	31. Date filed (Month, Dey, Year) 32. Registrar's Signeture			
Registrar	DCT 1 8 2000 Denus & Spark	4		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#9perFH,#26 perPhyG788 10/18/2000 EW Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2000 2:15 am 0 6 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Baltimore baltomore Baltimore, If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Ye 9. Birthplace (State or Foreign Country)

LIACH BUAL NC Funeral Months Davs Hours 7756 M 20F 212-12-Director Harch 07 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Bultimore Baltimore Yes 2 No Funeral Director Nerna 23a or 28a-f the Medical Examiner must be notifi 109 Street and Number 10f Zin Code 10g. Citizen of What Country? 3014 21215 Koselina USA 12. Was Decedent Ever in U,S. Armed Forces? Decedent Ever in U,S. Armed Forces? Decedent Ever in U,S. Armed Forces? Types 2 □ No If Yes, Give Year or Dates: UN 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filled within 72 hours after 1 Never Married Married ò Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ♥ No Specify by Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Loch Raven Library Eiementary/Secondary (0-12) College (1-4or 5+) Truck Driver Towson 11th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) h and Mental F Is marked of Sam Satterwhite Elizabeth Satterwhite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 2059. 3014 Rosalind Avenue Vernice Satterwhite - Wife Baltimore, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 10-11-00 Balto Co, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West Wabash Avenue Baltimore, Md 21215 23al Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) inknown Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last the buriel-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical Due to (or as a consequence of): signed by the attending to be detached for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 Probably 4 Unknown 1 Yes 2 No Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? has 28 No 30 No 1 Yes this certificate Attending Physician: director, 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 Yes No Other: 4 Nursing Home 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? After t Natural 5 Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yas 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

Greenquali 31. Date filed (Month, Day, Year) OCT- 1-8 State Registrar

(Check only one)

29b. Signature and title gl-eecifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MMMS

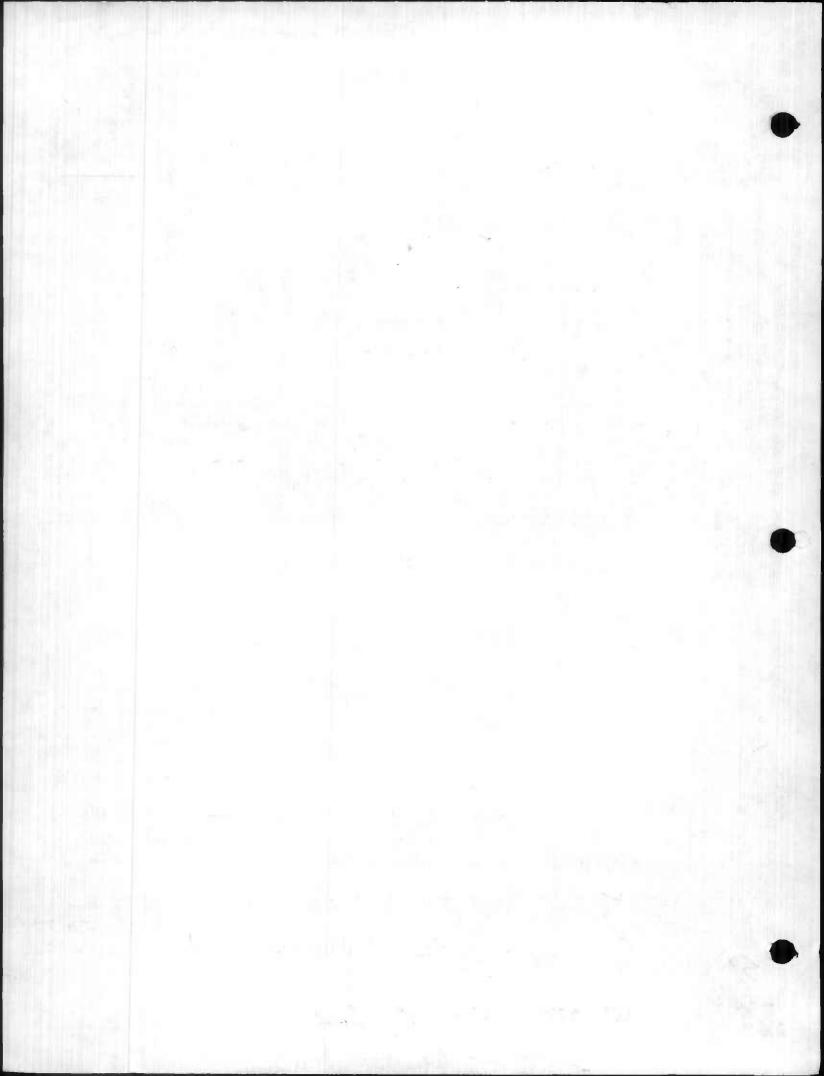
2000

32. Registrar's Signature

29c. License number

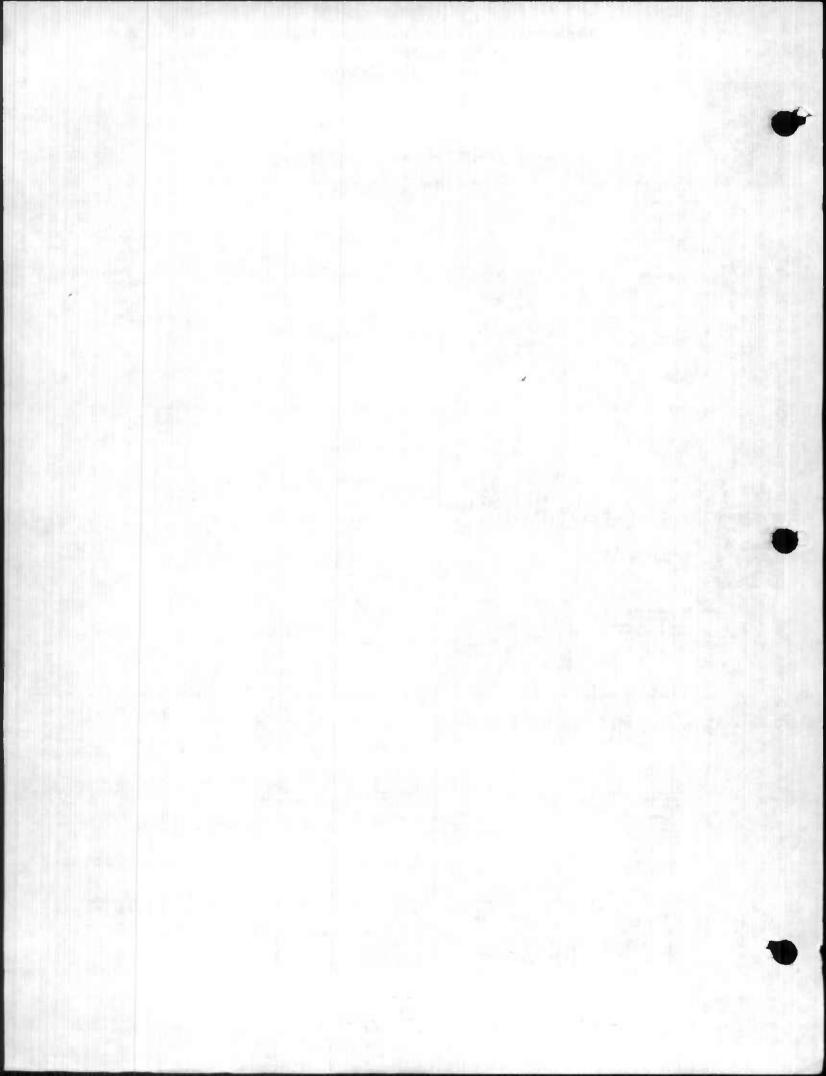
29d. Date signed (Month, Day, Year)

Baltomore, MD



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Physician	1. Decedent's Neme (First, Middle,	Last)					Death	2. Date of De		3	3. Time of Death
	ALAN JOSEPH	SEBREE						Month SEPTEN	Day BER 27,	Yeer 2000	17:10 PM
/Medical Examiner	4a Facility Neme (If not institution,	give street end number	7)				b. City, Town, or				17.30 111
	25 PENDRAGON CO	OURT					REISTE	RSTOWN	BA	LTIMOR	E
Funeral Director	218-48-4518	6. Sex 1 23 M 2 ☐ F	ge (In yrs. 52	last birthday) Yrs.	If Unde Months	Days	If Under 24 Hrs Hours Min.	8. Date of Bi (Month, Di Oct 6,	rth ay, Year) 1947	9. Birthplace Country)	a (State or Foreign MD
ž m	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Loc	ation					10d.	Inside City Limits
fied a	MD Balt	imore		Reist	erst	own					1 ☐ Yes 2 ☐ No
at be notified at Director	10e. Street and Number 25 Pendragon Co	urt			10f. Z	p Code	2	1136	10g. Citizen of \	What Country	?
Examiner must Examiner must by Funeral	11. Merital Status  1 👸 Never Merried 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Wes Deceden Armed Forces at 1 Yes 2 K If Yes, Give Yeer or Detes	?   No			dent of H ecity Cuba 2∑ No	ispenic Origin? (S In, Mexicen, Puer Specify:	pecify Yes or No to Rican, etc.)		ca - American ck, White, etc.	
ygiene. wer than "natur it, the Medical Completed	15. Decedent's (Specify only highest Elementery/Secondary (0-12)	Education grade completed)	5+)	life. D	kind of w	bled	during most of wo	rking	16b. Kind ot B	none	try
d other svent, g	17. Father's Neme (First, Middle, L	ast)			uISa	DICC	18. Mother's Na	me (First, Middle	, Maiden Suman		
Aenta the sy To B	Gordon F. Seb	ree				536	Lill	ian Con	ner		
27 is me r traums	19e. Informant's Neme/Reletionsh O . C . M . E .	p (Type, Print)		19b. Meiling 111 P			and Number or Ad et Balt	ural Route Numb imore, N		_	ode)
ut: If them ary or other	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremetion  4 ☒ Donetion — 5 ☐ Other (Special Control Contr			Plece ot Dispos semetery, crem			ce)	Dete	20c. Location	- City or Town,	, Stete
Depart Import any inj ance	21. Signature of Funda a Service Licensee Rohald S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201										
n and ial-transit Examiner	disease or condition resulting in deeth)  Sequentially list conditions	a. PONTINE	Due to (o	r es e consequ	uence ot	:	SUBDURAL H	IEMORRHAGE			
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o attend for u	Dad II Other simificant condition	a contributing to doub	but not room	ulting in the co	ala aluta a		on in Dard I	22h Did	tohooso usa sa	ntribute to th	e cause of death
detached	Part II. Other significant condition  ACUTE AND CHRONIC		but not res	uiting in the un	denying	cause giv	en in Per I.		Yes 2 No		e cause of death
2 shou								24a. Was	s an eutopsy ormed?	evaila	autopsy tindings ble prior to letion of ceuse ath?
page Com								158	Yes 2□No	1980 Y	es 2 No
is certificate director, pag To Be Co	25. Wes cese reterred to medicet examiner?	Hospitel:			1111	Oth	er	eth (Check only	_		
9 0	1  Yes 2 No  27. Menner of Death 1 Neturet 5 Pending 2  Accident investige	28a. Dete of Inj	ury	28b. Time of Injury 4:52	3□ C P M	28c. Injur Wor	4 LI Nursing F	dome 5 ☐ Res 28d. Describe	how Injury occur	ner (Specify) rred subje	
er in	3 Suicide 6 Could no 4 Homicide determin	t be	njury - At ho		et, fecto	ry, office		City or To	(Street and Number, State) 25 town, Md.	Pendrag	on Court,
n 24 hours he Funeral pletely filled edical C		Physician: To the best xaminer: On the basis of end manner s	of examina								
within 2 comple	29b. Signeture and title of certitier	onu manner s	ieleu.		25	c. Licens	e number		29d. Date signe	ed (Month, Da)	y, Year)
7 - 0	) QIN	1. 12				(	O.C.M.E.		SEPTEMB	ER 28.	2000
				23e) (Type, F							3000



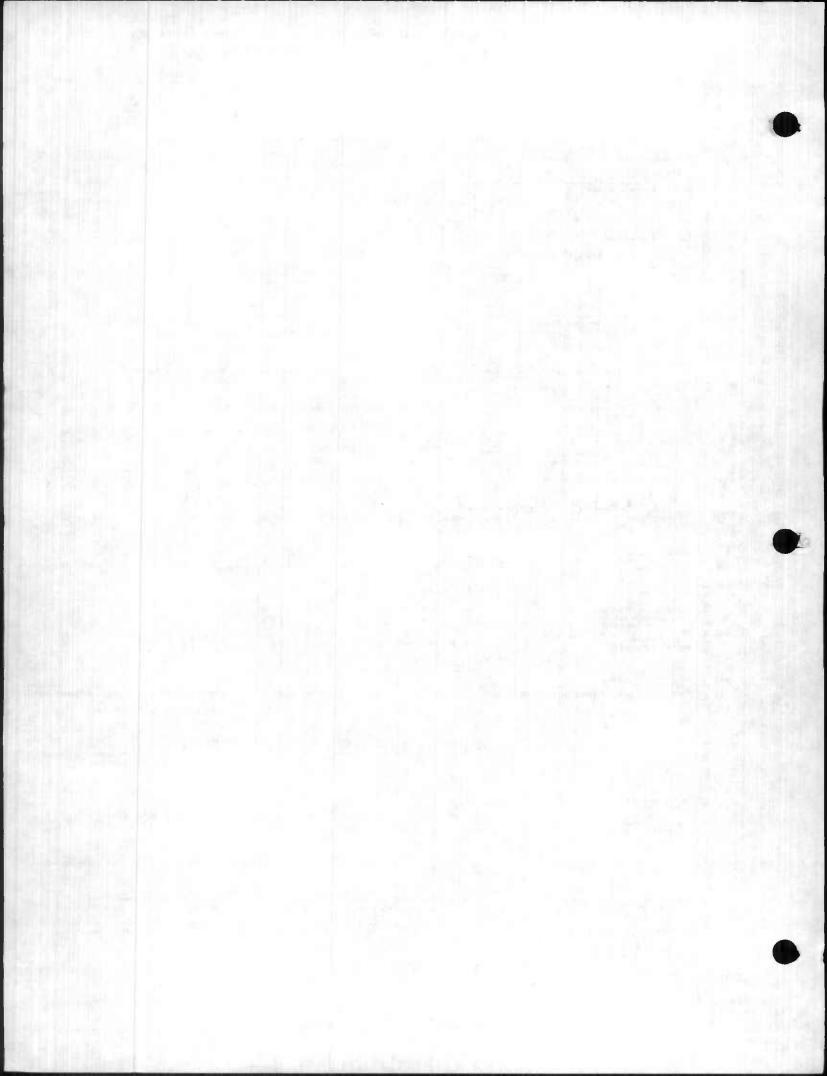
## Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Colon Surles 5:00 am 00 4b. City, Town, or Location of Death /Medical 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner University of Maryland Medical System Baltimore 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) 04-26-27 5. Sociel Security Number 1□M 2□F Yrs. 213-28-1103 73 SC Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Name 23a or 28a-f show XX Yes 2 No Director MD NA Baltimore oficel Examiner must be notifie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1511 N. Bond Street 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. hours after 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married 8 Maryland 21215-0020 1 ☐ Yes 200No Specify. Specify: Aq 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) NA Elementery/Secondary (0-12) 8th Grade Construction Co. Construction 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be should be trid Mental I Surles Talon Surles Coral Lee 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21213 19e. Informent's Neme/Reletionship (Type, Print) Health Hem 27 I 1511 N. Bond Street Baltimore, Maryland Mariah Brown Saltimore, 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 8 Buriel 2 Cremetion 3 Removal from Stete Voshell Mem. Gardens 10-20-2000 Dundalk, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21202 odes WM.C.March FH 1101 E. North Avenue Ware 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Polymicrobial Bacteriamia Examiner Due to (or as e consequence of): Physician/Medical Examiner Urosepsis/Osteomyelitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es e consequenca of): Bud The law requires that the death certificate be execu Decubitius Ulcers 68760 physician that initiated events resulting in death) Last Due to (or es e consequence of): as the Box esn. P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by 1 Yes 2 No 3 Probably 4 Unknown Dementia, Malnutrition by of Vital Records, 90 24b. Were autopsy findings aveileble prior to completion of cause of deeth? Completed 24a. Was en autopsy page 2 should performed? this certificate hes 1 ☐ Yes 2 No 1 Yes 2 No Attending Physician: Be 25. Was casa referred to medicat examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitel: 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 27. Menner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 Neturel
2 Accident Injury I or Attending after death. 1 Yes 2 No the . 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner steted. 29a. Certifier completely (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) P14751 Oct. 16, 2000 eath (Item 23a) (Type, Print) 30. Name and address of person who ted cause of GREENE ST. BALTO MD ZIZOI 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State Registra



#### Please Type or Print in Black Indelible Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day PAULINE SOMERVILLE IC 115 QAM 00 4b. City, Town, or Location of Deeth 4e Facility Nema (If not institution, giva street and number) 4c. County of Death Home nore 19 vinaa If Under 24 Hrs. If Under 1 Yeer 5. Social Security Number 8. Deta of Birth (Month, Pay, 6. Sex Aga (In yes last birthday) 9. Birthplace (Stata or Foraign -22-93 Months Days Hours Min 1 M 2 F Yrs. 21/VOY Carolina Usual Residence of Decedent 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 □ No Maryland mor 10e. Street and Numb 10g. Citizen of What Country? 10f. Zip Coda 0 d ol 14. Race - Amarican I Black, Whita, etc. 12. Was/Decedant Evar in U.S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No If Yas, specify Cuben, Maxican, Puarto Rican, atc.) Amaricen Indian 11. Merital Status 1 Yas 2 No If Yas, Give Yaar or Datas: 1 Never Married 2 Married 1 Yas 2 No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grada completed) 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. PO NOT usa retired) 16b. Kind of Business/Industry Elemanjary/Secondary (0-12) College (1-4or 5+) 18. Mothar's Nama (First, Middla, Maiden Surnama) 17. Fathar's Name (First, Middla, Last) 19e, Informent's Neme/Ralationship (Type, Print) (daughter) Rural Routa Number, City or Town, State, Zip Code, 19b. Mailing Address (Street and Number or Ville 2/2/5 omer 170, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Steta 20a, Mathod of Disposition Data 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Othar (Specify) Son rore 22. Name and Address of Facility ph a Ave OrTh the dictions, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, court fairned. List only one cause on each line. Approximata Intarval Betwaan Onsat and Death tmmediate Cause (Finel disease or condition rasulting in death) PNEUMONIA ASPIRATION 2 months Dua to (or as e consequence of): 6 months Sequentially list conditions, if any, leading to immediata ceuse. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Dua to (or as a consequence of) 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 1 Yaa 2 No 3 Probably 4 Dunknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was en autopsy 200 No 1 Yes 1 Yas 2 No 25. Was casa referred to medicel 26. Placa of Daath (Chack only ona) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Dey Year) 27. Mannar of Death 28d. Dascribe how injury occurred Injury at Work? 5 Pending invastigation 1 Neturel 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicide 6 Could not be detarmined

/Medical Examiner DmmeRu o after death.

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

r 28a-f show

than "natural", or items 23s or the Modern Exercises or

7 is marked other traumatic avent,

Department of Health at Important: If hem 27 is any injury or other trau

**Physician** 

Peges 1 and 2 should be filed within 72 hours after deeth vinent of Health and Mental Hyglene. Int: If Hem 27 is marked other than "natural", or flema 23

Baltimore, Maryland 21215-0020

Directo

Funeral

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Completed

Be

Physician/Medical Examiner

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Be Completed

edicai Certification: To

22

To the Hospital or Attanding within 24 hours after de To the Funeral Directo completely filled in by t

State Registrar

DHMH 16 Ray 6/95

31. Data filed (Month, Day, Year) - -OCT 1 8 2000

4 Homicide

29b. Signatura and titla of certified

Henra

29a. Certifier (Check only one)

30. Name and addrass of person who completed sausa of death (Item 23a) (Type, Print) Belvedere Avenue 32. Registrar's Signetura

m.D

Cuerda

Baltimore

Maryland

Certifying Physician: To the best of my knowledge, death occurred at tha time, dete end plece, and due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated.

29c. License number

D 54739

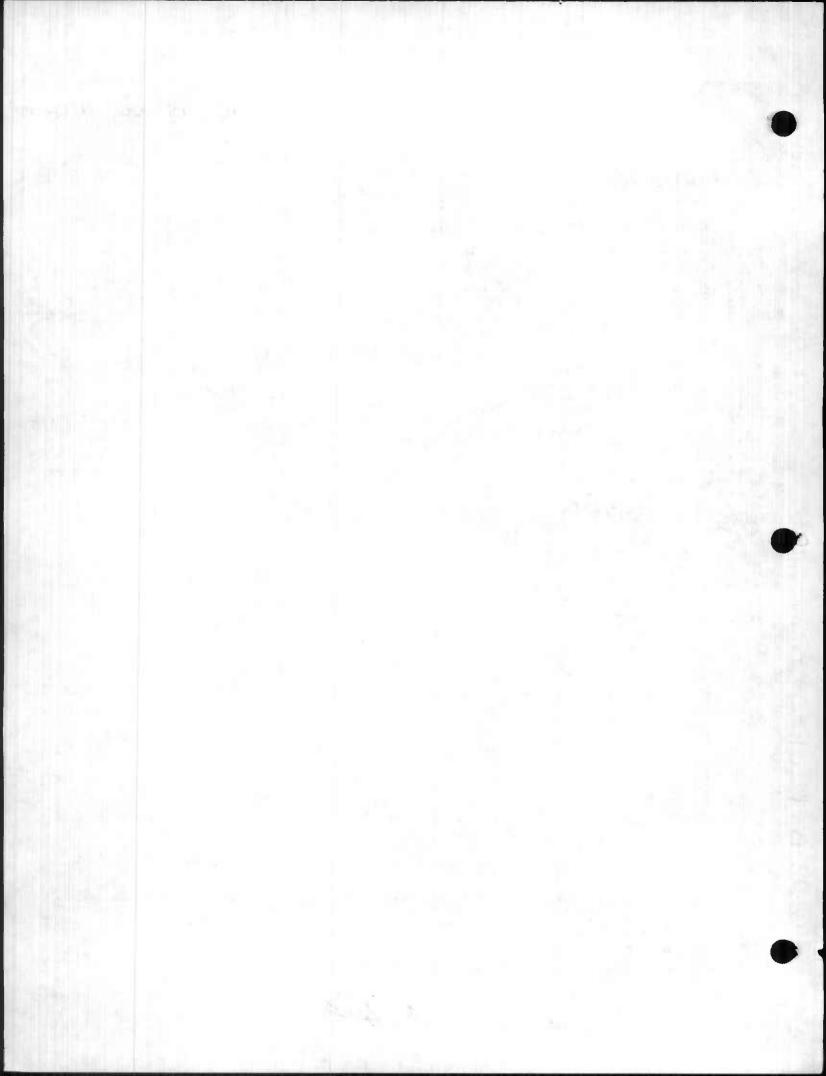
28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

21215

29d. Data signad (Month, Day, Year)

OCTOBER 16th 2000

28a. Place of Injury · At home, farm, straet, factory, office building, etc. (Specify)

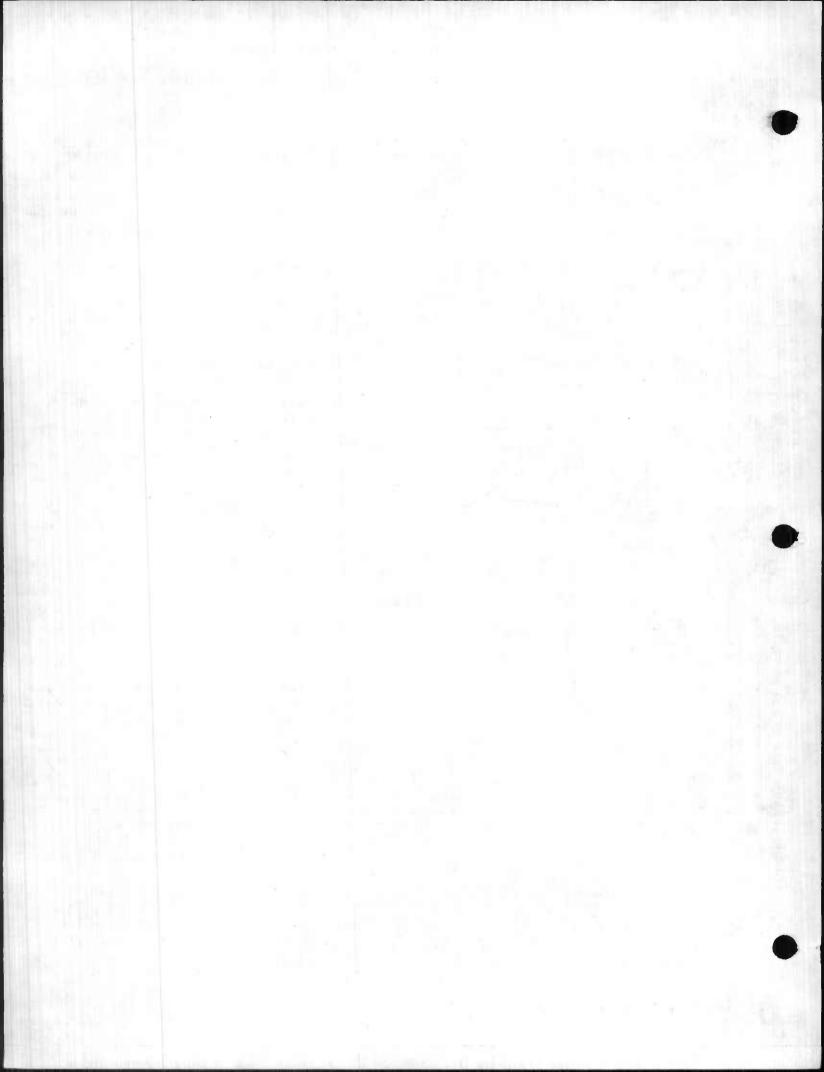


# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

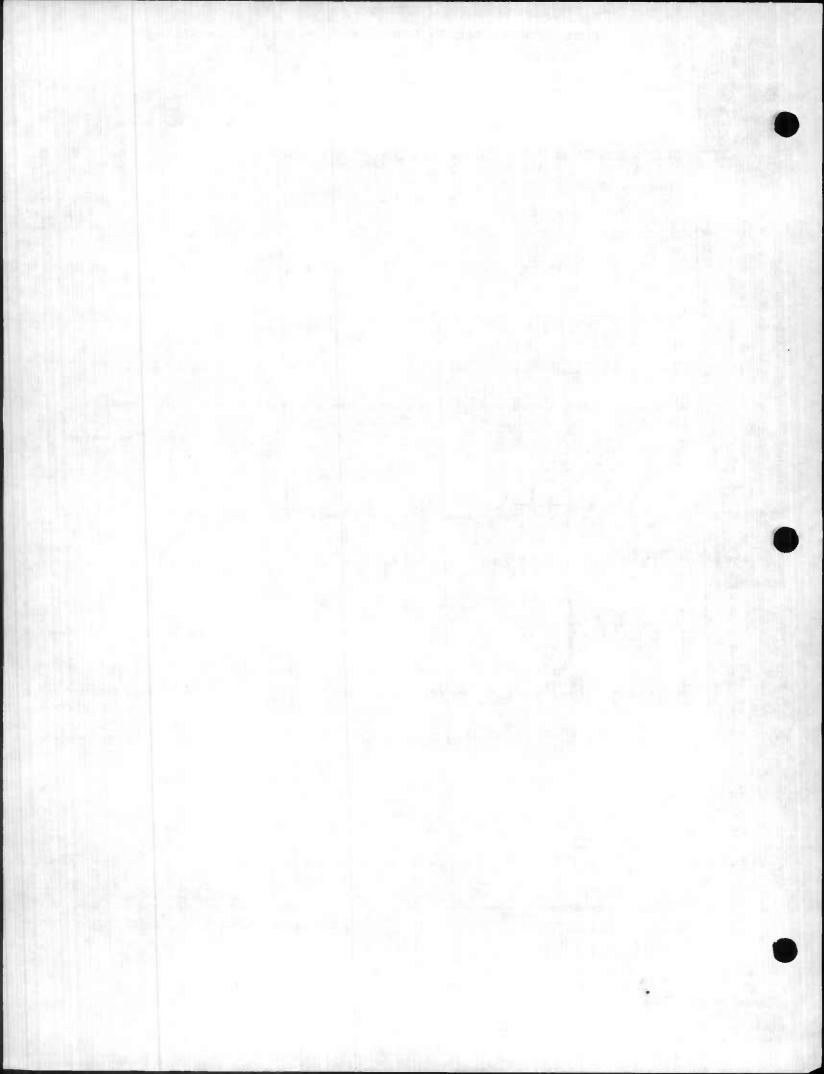
All and		Certificate of Death	R	leg. No. UU 3295/				
Physician /Medical	1. Decedent's Neme (First, Middle, Last) Mary Elizabeth Saunders		2. Dete of Dea Month October	Dey Year 4.25 AM				
Examiner  Funeral  Director	4e Facility Neme (If not institution, giva street and number)  North Anndel Hospit  5. Social Security Number 6. Sex 7. Age (In yrs. lest birth 217–16–8783 1	tal Glen.		(Year) Country)				
	Usual Rasidence of Decedent  10a. Stete 10b. County 10c. City, Town  Maryland Anne Arundel Odent			10d. Inside City Limits 1 ☐ Yes 2 ☒ No				
é 9 2	10e. Street and Number 372 Baltimore Ave.	101. Zip Code 21113		Og. Citizen of What Country? United States				
020 urs after Mr. or No	11. Maritel Sletus  1 Never Merried 2 Married  3 Widowed 4 Divorced  12. Wes Decedent Ever in U,S. Armed Forces?  1 Yes 2 No If Yes, Give Yaer or Detas: 1944-146	13. Wes Decedent of Hispanic Origin? It Yes, specify Cuban, Mexican, Pu  1 ☐ Yes 2 ☒ No Specify:	(Specify Yes or No-	14. Race - American Indian, Bleck, White, etc.  Specify: White				
T c ' #	(Specify only highest grade completed)  Flementery/Secondary (0.12)  College (1.4or 5.4)	Decedent's Usuel Occupation (Give kind of work done during most of w life. DO NOT use ratired) IEMAKET	vorking	16b. Kind of Business/Industry Own Home				
aryland should be file and Mental Hy marked oth umatic event	17. Fether's Nema (First, Middla, Last) Herbert E. Knickman	18. Mother's N Rose Fi	ame (First, Middle, i sher	Meiden Sumeme)				
Mar.	Frederick S. Saunders / Hus. 37	Meiling Address (Street end Number or 2 Baltimore Ave.,						
Baltimore, Maryland 212 permit. Pages t and 2 should be filed withi Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the M page.  To Be Comp	20a. Method of Disposition  1 Burial 2 Cremetion 3 Removel from Steta 4 Deduction 5 Other (Specify)  20b. Plece of Disposition (Name of cemetory or other plece) Crownsville MD Vet. Cem. 2000  20c. Location - City or T Crownsville Crownsville MD Vet. Cem. 2000  21. Signature of Fund of Service Licensae  22. Name and Addrass of Facility Kirkley-Ruddick Funeral Home, P.A.							
Balt permit. Depart Import any Inj ance.	· AP al all	421 Crain Hwy., S	.E., Glen	Burnie, MD 21061				
S8760, licate be executed licate be executed brysician and sthe buriel-transit edical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	e deart fail onsequence of):  Autery Dise	we	Interval Between Onset end Death				
	resulting in death) Last	жівецивнов оту.						
Is, P.O. Box as that the death certi signed by the attending be detached for use a by Physician/M	Pert II. Other eignificant conditions contributing to death but not resulting in	tha undarlying cause given in Pert I.		obacco use contribute to the cause of death?				
Record he law requir a has been singe 2 should ompleted			24a. Wes a perform	med? aveilable prior to completion of cause of death?				
Division of Vital Related at the interpretation of Attended Physician: The interpretation of the function of the function of the function. To Be Comertification: To Be Comertification:	25. Wes case reterred to medical exeminer?  1	patient 3 DOA Other: 4 Nursing me of jury at Work?		ence 6 Other (Specify) ow injury occurred				
Division o To the Heapital or Attending Ph Within 24 hours after death, To the Funeral Director: After th completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of this pullding, etc. (Specify)		City or Town					
he Hospi in 24 hou he Funer ipletaly fill	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examinetion end end manner steted.	deeth occurred et the time, date and pla /or investigation, in my opinion, deeth oc	ce, end due to the c curred at the time, d	ause(s) end menner as stated. late end piece, and due to the cause(s)				
To with the state of the state	29b. Signetura end title of certifier  Aleogu C. With III	M.D., 29c. License number D41365	2	2000 Date signed (Month, Dey, Year)  October 13, 2000				
4	Jeoge C. With III   30. Name and address of person who completed cause of death (floor 23a) (The Conference of the Confe	301 Hospital Du	rive, Gle	n Burnie 21061				

State Registrar 31. Dete filed (Month, Day, Year)
OCT 1 8 2000

Berry Sports



ician	1 23a,27,28,a,b,c,d,e,1 1. Decedent's Neme (First, Middle, L CHRISTOPHER G.	ast)		1 1		2. Dete of I Month OCTOB	Day	Yeer 2000	3. Tima of Deeth 0415
dical niner	4e Facility Neme (If not Institution, g	ive street end number)			4b. City, To	own, or Location of De			0110
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al or	212-90-5918	Sex 1		Months Do		Min. DEC.	Birth Poer) 1961	9. Birthple Countr MARYL	ce (State or Foreig AND
	Usual Residence of Decedent  10a. Stete 10b. County	10c. C	city, Town or I	Location				10	d. Inside City Limit
tor	MARYLAND ANNE A	RUNDEL	FERN	IDALE					1 ☐ Yes 2☐N
Funeral Director	10e. Street and Number 207 OAKLEIGH AVE			10f. Zip Cod	1061		10g. Citizen of V UNITED		
nera	11. Meritel Stetus	12. Wes Decedent Ever in Armed Forces?	U,S. 13	. Wes Decedent	of Hispenic O	rigin? (Specify Yes or n, Puerto Rican, etc.)		e - Americe	n Indien,
ò	1 ☐ Never Merried 2 ☐ Merried 3 ☐ Widowed 4 Å Divorced			1 Yes XX				ck, White, ei	
eted	15. Decedent's I (Specify only highest g	Education rede completed)	16e. Dec	edent's Usuel Or re kind of work di DO NOT use re	cupation one during mo	st of working	16b. Kind of Bu	usiness/Indu	stry
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o Be C	17. Fether's Neme (First, Middle, Las ELDRED GEORGE					er's Neme (First, Midd		ne)	
F	19a. Informent's Neme/Reletionship		19b. Mai	iling Address (St	reet end Numb	per or Rurel Route Num	nber, City or Town,	State, Zip (	Code)
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	20e. Method of Disposition 11 Binjel 2 Cremetion 3	MUSITIONAL HOLL STREE MEV	cemetery, cr	oosition (Neme of emetory or other GE MEM.	PK.	2000	ELKRID		
	4 Dorletion 5 Other (Spec			22. Name end A			DERRIED	02, 111	
	1 Att 18	111				FUNERAL H		- 0101	
	23a. Pert1. Enter the disease, or con shock, or heart feilure. List on	mplications that caused the decrease on each line.	42 eth. Do not e		dying, such es	E. GLEN B s cardiac or respiretory	arrest,		Approximate nterval Between
									Onset end Death
	Immediate Cause (Finel disease or condition resulting in deeth)	. NARCOTIC INTO							
ner		Due to	(or es e cons	equence of):					
Examiner	Sequentially list conditions,	Due to	(or es e cons	equence of):					
cal E	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events	c							1000
_	resulting in death) Lest	Due to (	or es e conse	equence of):					
3		d						1	
63	Pert II. Other significant conditions	contributing to death but not re	sulting in the	underlying ceus	given in Pert	I. 23b. D	id tobacco use co	ntributs to	the cause of deat
ysicia						1	□ Yes 2□ No	3 Prob	ably 4 ©¹Unkno
						24a. W	es an autopsy orformed?	24b. Wei	e autopsy findings leble prior to
þ						Pe	1101111001	com	pletion of cause eath?
þ							/		Yes 2□ No
Š						1)	Yes 2 No	10	
Be Completed by	25. Wes case referred to medical examiner?	Hospitel:			Other	e of Deeth (Check on	ly one)		
1: To Be Completed by Physician/Med		Hospitel: 1 ☐ Inpatient 2 [ 28s. Dete of Injury	28b. Time	of 28c.	Other: 4 N	e of Deeth (Check on	ly one)	ner (Specify,	
To Be Completed by	examiner?  1	28a. Dete of Injury (Manth, Dey Year) found: 10/14/00	28b. Time Injury unknow	of 28c.	Other	ursing Home 5 Ae  28d. Dascrit unknowr	ly one) esidence 6 Oth	ner (Specify,	
To Be Completed by	examiner? 1 Yes 2 No 27. Manner of Death 1 Neturel 5 Pending	28a. Dete of Injury (Manth, Dey Year) found: 10/14/00	28b. Time Injury unknow	of 28c.	Other: 4 Ninjury et Work?	ursing Home 5 Re 28d, Descrit Unknown	ly one) sidence 6 Oth se how Injury occur 1	ner (Specify,	Route Number
Certification: To Be Completed by	examiner?  1  Yes 2  No  27. Manner of Death 1  Neturel 5  Pending Investigeti 3  Suicide 6  Could not determine  2  Accident determine	28a. Dete of Injury found: 10/14/00 28e. Piece of Injury - At building, etc. (Spec found at home	28b. Time Injury unknow home, ferm, sify)	of 28c.  The Market Actory, of the Ath occurred et the Ath occurre	Other: 4 N	Le of Deeth (Check on: ursing Home 5 Re 28d, Describ Unknown 28f, Location City or Glen Bu	esidence 6 Other how Injury occurs to the form of the state of the sta	ner (Specify, rred ber or Rurel Oaklei	Route Number, gh Avenue
edical Certification: To Be Completed by	examiner?  1  Yes 2  No  27. Manner of Death 1  Neturel 5  Pending Investigeti 3  Suicide 6  Could not determine  2  Accident determine	28a. Dete of Injury found:  10/14/00  28e. Plece of Injury - At building, etc. (Spec found at home	28b. Time Injury unknow home, ferm, sify)	of 28c.  The Market Actory, of the Ath occurred et the Ath occurre	Other: 4 N	Le of Deeth (Check on: ursing Home 5 Re 28d, Describ Unknown 28f, Location City or Glen Bu	esidence 6 Other how Injury occurs to the form of the state of the sta	ner (Specify, rred ber or Rurel Oaklei	Route Number, gh Avenue
Certification: To Be Completed by	examiner?  1	28a. Dete of Injury found:  28a. Dete of Injury found:  10/14/00  28e. Plece of Injury - At building, etc. (Spec found at home	28b. Time Injury unknow home, ferm, sify)	of 28c.  TO M 28c.  street, factory, of the occurred et the investigation, in a 29c. Lie	Other: 4 Ninjury et Work? 1 Yes 2 Cice	Le of Deeth (Check on: ursing Home 5 Re 28d, Describ Unknown 28f, Location City or Glen Bu	esidence 6 Other how Injury occurs to the form of the form, State) 207 armie, MD.  In (Street and Numbrown, State) 207 armie, MD.  The cause(s) end mue, dete end place, 29d. Date signe	her (Specify, red ber or Rurel Oaklei enner as sta and due to	Route Number, gh Avenue ited. ited cause(s)
edical Certification: To Be Completed by	examiner?  1	28a. Dete of Injury found:  28a. Dete of Injury found:  10/14/00  28e. Plece of Injury - At building, etc. (Spec found at home physician: To the best of my knammer: On the bests of exeminand menner steted.	28b. Time Injury Unknow home, ferm, s	of 28c.  The Modern Mod	Other: 4 N	Le of Deeth (Check on: ursing Home 5 Re 28d, Describ Unknown 28f, Location City or Glen Bu	esidence 6 Other how Injury occurs in (Street and Numbrown, State) 207 irrnie, MD.  The cause(s) end make, dete end place,	her (Specify, red ber or Rurel Oaklei enner as sta and due to	Route Number, gh Avenue ited. the cause(s)



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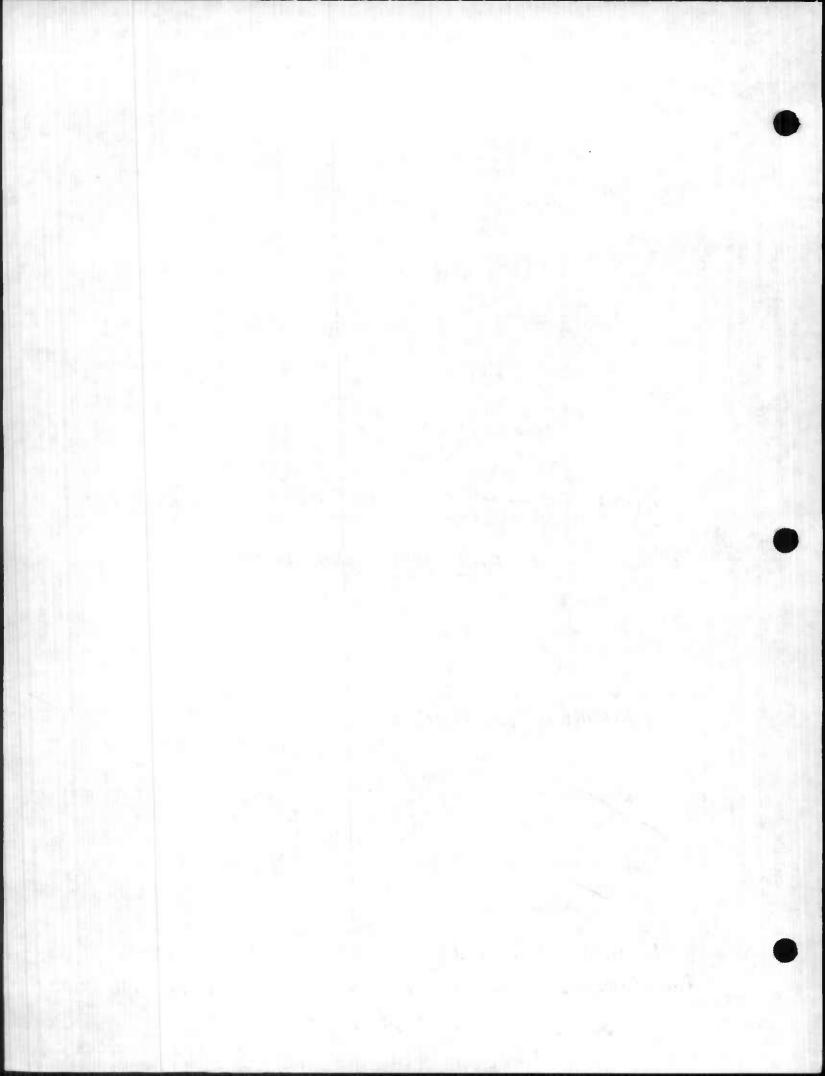
State of Maryland / Department of Health and Menta	I Hygiene	32959
Certificate of Death	Reg. No.	5650.

Physicia	Lulin Geneva						2. Date of Do Month October	Dey	Yeer 2000	3. Time of Death 10:30pm
/Medica Examine	do English bloom a 115 mod in atitudi	on, give street end n	um <i>ber</i> )			4b. City, Town, or			y of Deeth	
50	Eastpoint Nurs	sing & Rel	hab			Eastpoin	nt	Balt	imor	e
Funeral Director	5. Sociel Security Number 218-22-7402	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yr. 82	s. last birthdey) Yrs.	If Under 1 Yes Months Dey			irth ley, Year) 1918	9. Birthi Cou Têni	plece (Stete or Foreign ntry) N •
2 .	Usual Residence of Decedent		100 (	City Town or La	anting					40d Incide City History
ter death with the Maryla herre 23s or 28s-f shor the mast be notified at	MD 10a. State 10b. Count	n/a	106. (	City, Town or Lo Ba	ltimore					10d. Inside City Limits 1 1 Yes 2 □ No
28a Dolli	10e. Street and Number				10f. Zip Code		-	10g. Citizen of	What Cou	ntry?
A SE		tt Street			212			USA		,
7 5 5 THE	11. Meritel Status		cedent Ever in	U.S. 13.			pecify Yes or N		ce - Ameri	can Indian,
	11. Meritel Status  1 Never Married 2 Ma	Armed F	orces? 2 No	,,,,	If Yes, specify Cu	f Hispanic Origin? (S uben, Mexican, Puer	lo Rican, etc.)	Ble	ck, White,	etc.
0.00	3 ☑ Widowed 4 ☐ Divorce	If Yes. G	live 1		1□Yes 2√N	o Specify:		Speci	y: Wh	ite
		nt's Educetion	DEC A	16a. Dece	dent's Usual Occ	upation		16b. Kind of E	Business/In	dustry
215 215 215 215 215 215 215 215 215 215	15. Decede (Specify only high Etementary/Secondery (0-12) 8th 17. Father's Name (First, Middle	est grade completed	(1-4or 5+)	(Give	kind of work don DO NOT use reti	ne during most of worred)	rking			
12 Swill	8th	College	(1-401 34)	Ног	memaker			In own	n hom	e
and the file and other cevent.	17. Father's Name (First, Middle	, Last)				18. Mother's Nar	ne (First, Middle	e, Maiden Sume	m <i>e)</i>	
	James Gribble					Maude	Bryant			
and who	19a. Informent's Name/Reletion	ship (Type, Print)	son	19b. Meili	ng Address (Stre	et and Number or Ri	ural Route Numi	ber, City or Town	, Stete, Zij	o Code)
and 2	Wayne Staton			62 R	iverview	Rd. West	. Delta	. Pa. 1	7314	
of a see	20a. Method of Disposition		20b	Piace of Dispo	osition (Name of metory or other p		Dete	20c. Location		own, State
aftimore, nit. Pages 1 ar artment of Hea oriant: If Nem. Injury or other	1 ☑ Buriel 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		C C	restlaw		(ece)	.0/18/2000	Baltimor	re, Mai	ryland
Ball permit. Departr Importu any inj	21. Signeture of Funeral Service	Micensee 3	ne		2. Name end Add	onkling Stre		Zannino Jr		
	23a. Part1. Exter the disease, o shock, or heart feilure. Lis	or count ations that	caused the de						yranu	Approximate
ox 68760, Ventificate be executed miding physician and use as the burial-transit	fmmediate Cause (Final disease or condition resulting in deeth)  Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or imjury	e	Due to	(or as a consector of the consec	quence of):	EMENT	1A		1	
Box 68760,  ath certificate be executed titlending physician and for use es the burial-transit		d	Due fo	(or es e consec	juence of):					
O. BO	Part II. Other significant condit	lons contributing to	death but not re	esulting in the u	nderlying cause	given in Part I.	23b. Dic	d tobacco use c	ontribute !	to the cause of death
15, P.O. Bo		E TO	o T	HRIVE	5		1 [	Yes 2□ No	3 Pro	obably 4 Unknow
requi					3-1		24e. Wa	s en eutopay formed?	a	Vere eutopsy tindings veilable prior to ompletion of ceuse f death?
T 9 4 5	5						1	Yes 20 No		☐Yes 2☐No
Vital I		el				26. Place of Se			1	
	axaminer?	Hospitel:	Inpatient 2	☐ ER/Outpatie	nf 3□ DOA	Wher:		sidence 6 🗆 Ot	har /Case	(6.1)
0 4 5 7			of Injury	28b. Time o			1	how injury occu		ny)
SION O tending Ph leeth. to: After th the funeral	1 Natural 5 Pend		nth, Dey Year)	Injury	N	Vork? ☐ Yes 2 ☐ No				
Z 4 2 2 2	2 Accident inves 3 Suicide 6 Could 4 Homicide	not be 28e. Plac	ce of Injury - At		reet, fectory, offic		28f. Location City or To	(Street end Num own, Stete)	ber or Rui	ral Route Number,
Hospital or 124 hours after Funeral Directory filled in		ing Physician: To the I Examiner: On the I and ma	e best of my ki basis of examin	nowledge, deet nation end/or in	h occurred at the vestigation, in my	time, date end plece y opinion, death occi	e, and due to the	e ceuse(s) and n	nenner as	stated. fo the cause(s)
di di di					29c. Lice	nse number		29d. Date sign	ed (Month	, Dey, Year)
-	Ramash	ankar	- MI				-6			
VV	30. Neme end eddress of person	n who completed cau	use of deeth (It	em 23e) (Type,	Print)			^		
State	KAMA SHAWK	AR, 2	4	9 BI	ACK RIV	04804 VER NEC	k Rd	, Ba,	MD	21221

Registrar DHMH 16 Rev 6/95

State

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death Vaar **Physician** Haze rancis 11:50 AM October 13 2000 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore
If Undar 24 Hrs. 8. Dete of Birl gnes 6. Sex OSPITA NA 8. Dete of Birth (Month, Dey, Year) If Under 1 Yaar 9. Birthplace (State or Foreign 5. Social Security Number Funeral Deys Months Hours 1 M 210 F 68 8646 213 26 864 Usuat Residence of Deceder Yrs. Director 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 PYYes 2 □ No altimore Director 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? b 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 516 Funeral 14. Race - American Indian, Bleck, White, etc. 11 Marital Status 1 Never Married 2 Married 1 Yes 2 WNo 8 Specify: 3 ☐ Widowed 4 Divorced lac 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) herapist hysicalTherapy pemit. Pages 1 and 2 should be filed to be sufficient to the sufficient of Health and Mental Hygie reprised other 1 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) 89 Tinnett JOSEP rown ar tha 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) 516 N. Battimore, mD 21223-1307
Dete 20c. Location - City or Town, State Arlington raren daystiter 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State butus Memorial Park 10/19/2000 trbutus, MID 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Gary P. March Funeral Home P.A.
270 Fredhilton Pass Bultimore, MD 21229 21. Signature of Funeral Service License are the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory arrest heart failure. List only one cause on each line. Approximata Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) · Multiple interes Dowel Days Examiner Dua to (or as a consequence of) , Atherosclerosis generalized Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Chsive Cardiovascular Disease Due to (or es a consequence of): Rena Stenosis artery ears Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did lobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? 1 Yes 1 Yes 2 No 2□ No 25. Wes case referred to medicat examiner? 88 26. Placa of Death (Check only ona) 1 Yes 2 No Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 27. Manger of Death 28d. Describe how injury occurred 28b. Tima of 28a. Date of Injury (Month, Dev Year) 28c. Injury at Work? Atter 1 Natural 5 Pending 1 Yas 2 No investigation 2 Accident

68760 P.O. Box Stinnett, Haze of Vital Attending i or Attend after deat Director:

altimore, Maryland 21215-0020

Division

To the Hospital within 24 hours a To the Funeral D Medical State Registrar

DHMH 16 Rev 6/95

29b. Signature and title of certifier

3 ☐ Suicide

29a, Certifier

4 ☐ Homicide

Decke

28e. Place of Injury - At homa, farm, streat, fectory, office building, etc. (Specify)

29c, License number

DON 96L

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred et tha time, data end piece, and dua to the cause(s) and manner steted.

29d. Date signed (Month, Day, Year)

October 16 2000

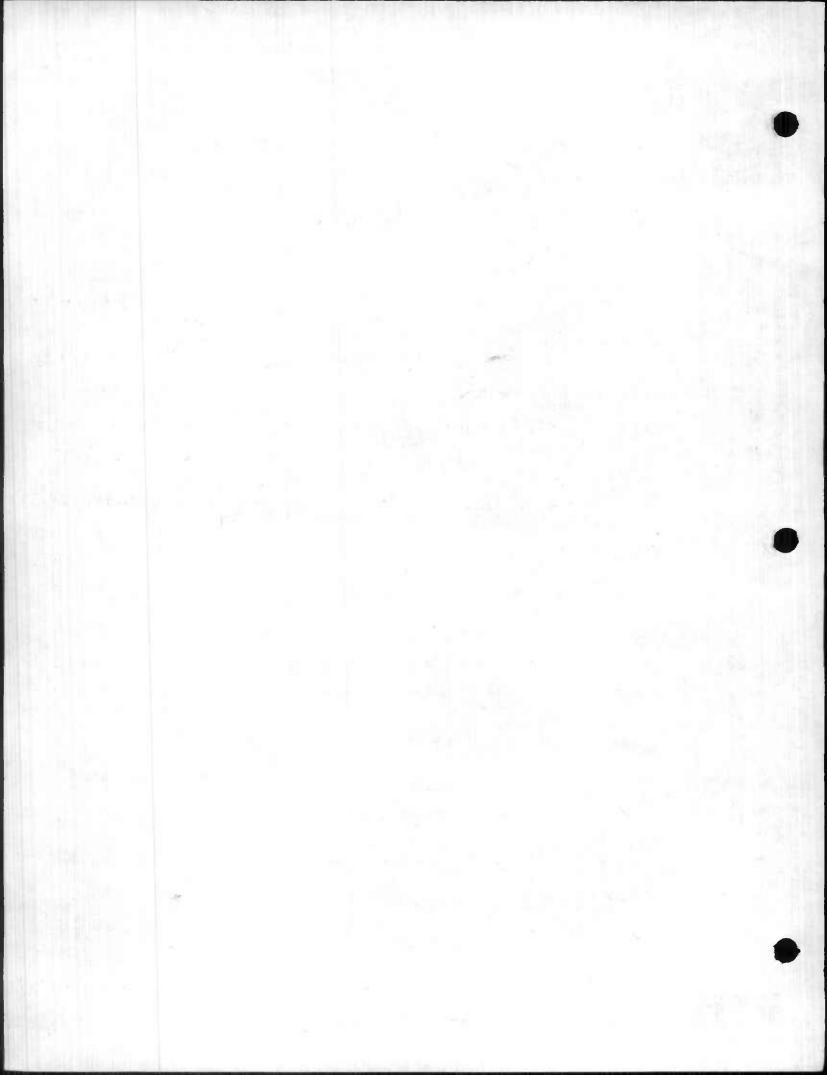
Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 Caton Arenve - Baltimore, MO. 21229 William J. Hicken, M.D. St. Agnes HealthCare 31. Date filed (Month, Day, Year) 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, daeth occurred et tha tima, data and place, and dua to tha cause(s) and mennar as stated.

6 Could not be



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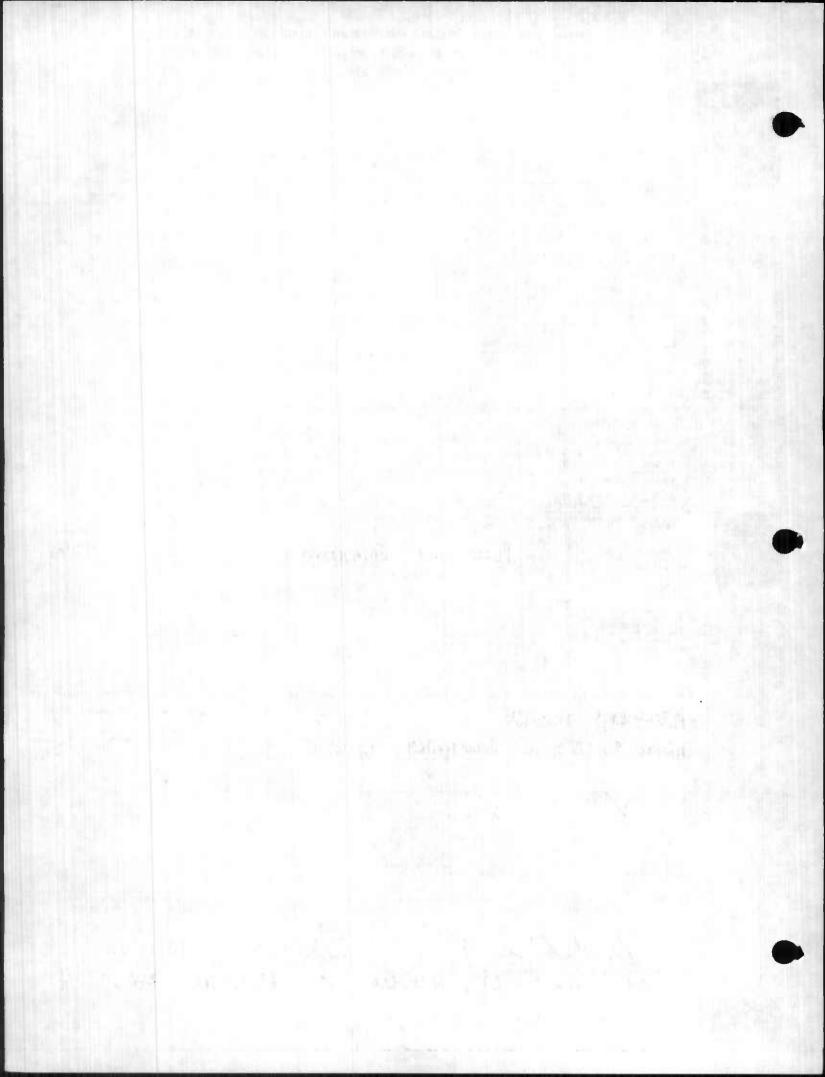
State of Maryland / Department of Health and Mental Hygiene 0 3 2 9 6 |

Certificate of Death

			Certif	icate of	Death	Re	ig. No.	02301
Di matata a	1. Decedent's Name (First, Middla, Last)	Mary Control	4317			2. Date of Death		3. Tima of Death
Physician /Medical	ELIZABETH MAR	IE SPILMAN				Octobe	r 13,2	2000 7:40am
Examiner	4a Facility Nama (If not institution, give stre		Man B		4b. City, Town, or Lo	ocation of Death	4c. County	
	Greater Baltimon				TOWSON  If Under 24 Hrs.	100	Balt	imore
Funeral Director	213 20 4704	7. Aga (In yrs. la 78		Under 1 Year onths Days	Hours Min.	8. Date of Birth (Month, Day, Nov. 2	Year) 4,1921	9. Birthplace (Stata or Foreign Country) Maryland
2	Usual Rasidance of Decedent  10a. Stata 10b. County	10c. City.	Town or Location	on				10d. Insida City Limits
23a or 28a-f show ust be notified at rai Director	Maryland N/A		ltimore					1∭ Yes 2 □ No
be notified Director	10e. Street and Number	Dai		Of. Zip Coda		10	og. Citizen of W	/hat Country?
T D	4100 N. Charles St	reet		2121	8		U.S.A.	
Examiner.m Dy Funer		Was Decedent Ever in U,S Armed Forces? 1 □ Yes 2 ሺ No If Yas, Giva Yaar or Datas:			Hispanic Origin? (Span, Maxican, Puarto	ecify Yes or No- Rican, atc.)	14. Race	e - Americen Indian, k, White, atc.
At the Medical Completed	15. Decedant's Educati		16a. Decedant	's Usual Occup	pation during most of work	ina	6b. Kind of Bu	sinass/Industry
able old	(Specify only highast grada co	College (1-4or 5+)	lifa. DO I	VOT usa retire	d)	ing		
Con the		4 yrs.	Homen	naker			Own Ho	
Be Be	17. Father's Name (First, Middle, Last)				18. Mothar's Name	a (First, Middla, N	faidan Sumam	a)
To To	FRANK GEORGE SCHEI				HILDA KE			
1 1	19a. Informant's Name/Ralationship (Type,				and Number or Run			
Ž.	David S. Spilman (So 20a. Mathod of Disposition		000/ Wa		ood Circl	-		City or Town, State
8	1 X Burial 2 □ Cramation 3 □ Ram	oval from Stata	matary, cramato	ary or other pla	,			
1	4 Donation 5 Other (Specify)	Dr	uid Rid	0				lle,Maryland
any in	21 Signatura of Funaral Sarvice Licensee	Kenaku		6500 Yo	Wiedefeld ork Road I	Baltimore	e, Maryl	Inc. and 21212
	23a. Part1. Enter tha diseasa, or complicate shock, or haart failura. List only ona complicate shock.	ons that caused the death.	Do not enter th	na moda ot dyi	ng, such as cerdiac	or raspiratory arre	st,	Approximate Interval Between
sician edical	Immediata Causa (Final	Pulmonn						HOURS
miner	disaasa or condition resulting in deeth) a				220			710010
ě ě		Dua to (or	as a consequan	ce ot):				
tal-transit Examiner	b	Due to for	as a consequen	on of):				1
	Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants	500 (0) (0)	as a consequen	00 01).				
s the bur	Cause (Disease or injury that initiated evants	Due to (or a	as a consequen	ca of):				
12° 18° 180	rasulting in death) Last							
for use	d							1
elached for use	Part II. Other eignificant conditions contrib	uting to death but not rasul	lting In tha undar	rlying ceusa gi	van in Part I.	23b. Dld to	bacco uae gor	tribute to the cause of death?
Phy	MZHEIMERS DIJE	ASSE				1 U Y	2 No	3 Probably 4 Unknown
8 6	-11		150.0					
page 2 should Completed	CHRONIC OFSTRUCTIVE	& DULMON.	HLY	OISEN	SE	24a. Was ai	n autopsy ned?	24b. Ware autopsy findings available prior to completion of cause
e 2 s				VIO			./	of death?
dor, page 2					5.75	1 □ Ya	s 200 No	1 ☐ Yas 2 ☐ No
32 MA	25. Was case rafarred to medicel examinar?	oital:		0+	26. Placa of Deat	h (Check only on	a)	
100	TU Yas 2LT NO	1 Unpetient 2 LE		3LI DOA	4 LI Nursing Ho	ma 5 Reside		
fund form	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Inju Wo	rk? Yas 2 No	280. Describe no	w injury occurr	90
ed in by the funera	2 Accident invastigation 3 Suicide 6 Could not be	28a. Plece of Injury - At hon			7183 20110	28f. Location (St	reet and Numb	er or Rural Routa Number,
a di	4 Homicide detarmined	building, atc. (Specify)	)	lactory, office		City or Town		or or ridial riddia ridinoor,
edical Cer		an: To the best of my knowl On the basis of examination						
Med	29b. Signatura and titta of certifier	and mannar statad.		29c. Licen:	se number	25	d. Date signed	(Month, Day, Year)
V	111-1.00	Inn		T	30433		10/14	100
10	30. Nama and address of person who comp	leted course of death (then	23a) (Tuna Drin				1	
()	M DXLY CASMIC			E( 8	1 614	ITIM ORK	M	121204
State	31. Data filed (Month, Day, Year)	32. Registrar's Signatu	ura /	,				
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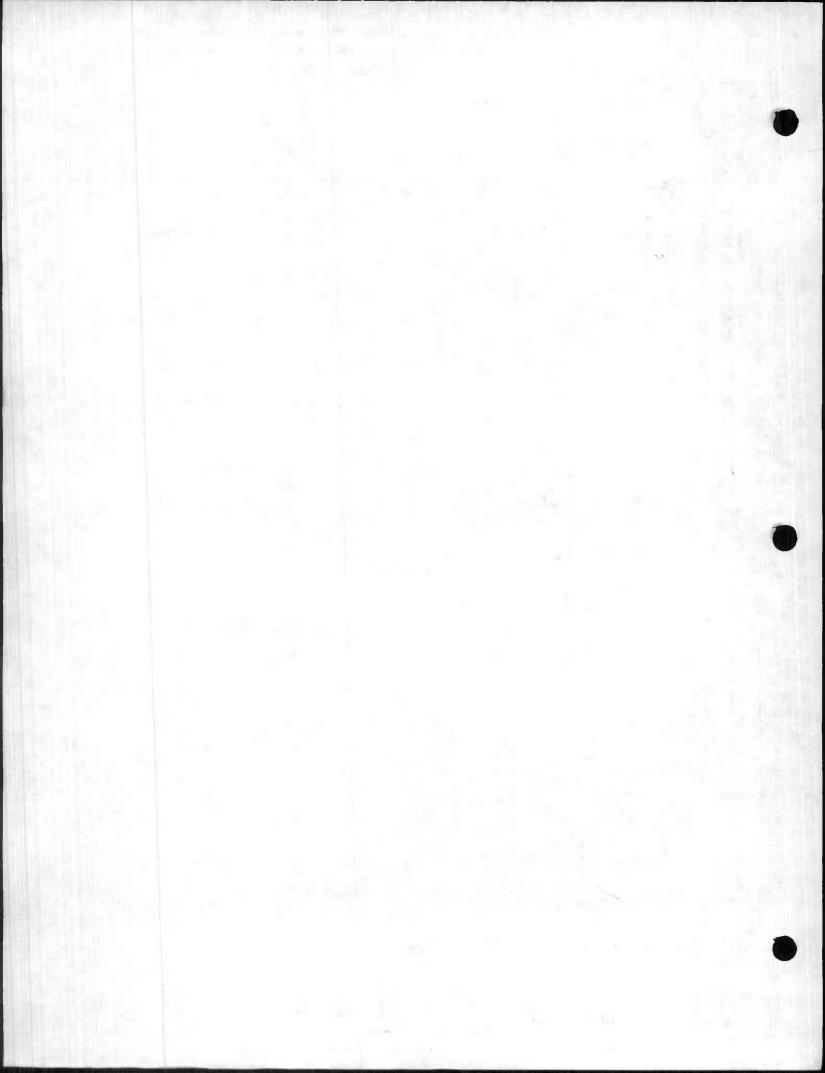
PHILIP STEVENS  COTOBER 15 2000 9:30  4a Facility Name (If not institution, give street and number)  8327 BROOKWOOD ROAD  Social Security Number 6. Sex 1/2M 2   F 65 yrs.    10				State of Marylan		artment of rtificate o				g. No,	0	3296
FHILIP STEVENS  SCORPER 15 2000 9:30  6. CBy, Tean, of Leating of Devis Annual Control of Parks  8.327 REDOKNOOD ROAD  13.329186  10. CCDW   Annual Control of Parks  10. Color   Color of Parks  10. Color of Parks  10. Color   Color of Parks  10. Color of Parks			. Decedent's Name (First, Middle, Last	)			154				Veer	3. Time of Dea
48 Festility Name if not netitation, plus stores and number?  48 Seattly Name if not netitation, plus stores and number?  49 Seattly Name if not netitation, plus stores and number?  50 Seattly Name if not netitation, plus stores and number?  50 Seattly Name if not netitation, plus stores and number?  50 Seattly Name if not netitation, plus stores and number?  50 Seattly Name if not netitation, plus stores and number?  50 Seattly Name if not netitation, plus stores and number?  50 Seattly Name if not netitation, plus stores and number?  50 Seattly Name if not netitation, plus stores and number?  50 Seattly Name if not netitation, plus stores and number?  50 Seattly Name if not netitation, plus stores and number?  50 Seattly Name if not netitation, plus stores and number?  50 Seattly Name if not netitation, plus stores and number?  50 Seattly Name if not netitation, plus stores and number?  50 Seattly Name if not netitation, plus stores and number?  50 Seattly Name if not netitation, plus stores and number?  50 Seattly Name if not netitation, plus stores and number?  50 Seattly Name if not netitation, plus stores and number?  50 Seattly Name if not netitation, plus stores and number?  50 Seattly Name if not netitation, plus stores and number?  50 Name is not not number?  50 Name is number?  50 Name is not number?  50 Name is number?  50 N		_	PHILIP	STEVENS						4 = 00		9:30 A
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10   10   10   10   10   10   10   10	ž	-		10c. City	, Town or Lo	ocation						10d. Inside City L
Market Salus   Market Salus   12. Web Dependent Ever in U.S. Armed Forces   13. Was Decedent of Hispapinic Origin? (Specify Yea or No. 1)   13. Was Decedent of Hispapinic Origin? (Specify Yea or No. 1)   14. Race - American Indian, Market Salus   11. Never Marind 20 Married   15. Decedent States or Delete   11. Never Marind 20 Married   15. Decedent States or Delete   11. Never Marind 20 Married   15. Decedent States or Delete   11. Never Marind 20 Married   15. Decedent States or Delete   15. Decedent States or Decedent States or Delete   15. Decedent States or Decedent St	to to	5	Md. Anne Aru	ndel Co. N	Miller	sville						1 🗆 Yes 2]
Market Salus   Market Salus   12. Web Dependent Ever in U.S. Armed Forces   13. Was Decedent of Hispapinic Origin? (Specify Yea or No. 1)   13. Was Decedent of Hispapinic Origin? (Specify Yea or No. 1)   14. Race - American Indian, Market Salus   11. Never Marind 20 Married   15. Decedent States or Delete   11. Never Marind 20 Married   15. Decedent States or Delete   11. Never Marind 20 Married   15. Decedent States or Delete   11. Never Marind 20 Married   15. Decedent States or Delete   15. Decedent States or Decedent States or Delete   15. Decedent States or Decedent St	irec	1	0e. Street and Number			10f. Zip Cod			10			ntry?
1			8327 Brookwood 1	Road			2110	8		USA		
The company of the	tems Marin	1		Armed Forces?	S. 13.	Was Decedent of If Yes, specify C	of Hispanic O Cuban, Mexica	rigin? (Spe an, Puerto	ecify Yes or No- Rican, etc.)	Blec	k, White,	etc.
15. Decedent's Education   16. Give her for do your driving marked of post driving driving marked on the file. On NOT user returned for post driving driving marked on the file. On NOT user returned for post driving driving marked driving marked for post driving driving marked for post driving driving marked for post driving file. On NOT user returned file. On Not user				1 Yes 2 No		1□ Yes 21XI	No Specify	<i>/</i> :		Specity	whi	te
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The part of Name (Prist, Mode), List)  Colris Stevens  Sophia Lucas  Iso. Maling Address (Street and Number of Rural Route Number), City or Town, State, Zip Code)  Toward Fuller (Daughter)  Towa	Diet		(Specify only highest grad	le completed)	(Give life.	kind of work do DO NOT use re	ne duning mo tired)	st of work	ing			
The surface states (prist, Modes, Last)  Colris Stevens  Sophia Lucas  Sophia Lucas  Sophia Lucas  Sophia Lucas  Sophia Lucas  Sophia Lucas  Table Informant's Name Palationanip (Type, Print)  Louan Fuller (Daughter Tyras Page of Daposotic (Name of Care Place)  Louan Fuller (Daughter Tyras Page of Daposotic (Name of Care Place)  To Burier Schoen (Special)  20b. Page of Daposotic (Name of Care Place)  To Burier Schoen (Special)  21 Signature of Funcion Sales  Baltimore, Md. 21122  22 Name and Address of Facility McCully-Polyniak Funeral Home P.A.  3204 Mountain Road, Passadena, Md. 21122  23a. Part f. Einer the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Immediate Cause (Final Interest Page)  Sequentially ist conditions  Sequentially ist condi	e the Co	5			Plum	ber				Local	Unic	n 486
Continued   Cont	1 5 0		7. Father's Name (First, Middle, Last)								Θ)	
Louann Fuller	To the	2								-		
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Baltimore, Md.	Page 1	2						e. Pa				own State
21. Signature of Funerel Service Licenses  22. Name and Address of Facility  McCully-Polyniak Funeral Home P.A.  3204 Mountain Road, Pasadena, Md. 21122  238. Parf. Enter the disease, or complications their causes the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest,  their responsibility of the service of	0 = 0	-	1 ☐ Buriel 24 Cremetion 3 ☐ F	Removel from Stete	emetery, cre	matory or other	place)					
MCCully-Polyniak Funeral Home P. A.  3204 Mountain Road, Pasadena, Md. 21122  23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate consequence of the cause (Final presulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Sequentially list conditions, and the cause of seath in the underlying cause given in Pert I.  23b. Did tobecco use contribute to the cause of seath in the underlying cause given in Pert I.  23b. Did tobecco use contribute to the cause of seath in the underlying cause given in Pert I.  23b. Did tobecco use contribute to the cause of seath in the underlying cause given in Pert I.  24a. Was an autopsy performed?  24b. Was an autopsy performed?  25b. Was case referred to medical seathing in the underlying cause given in Pert I.  25b. Did tobecco use contribute to the cause of seathing in the underlying cause given in Pert I.  25b. Did tobecco use contribute to the cause of seathing in the underlying cause given in Pert I.  25b. Did tobecco use contribute to the cause of seathing in the underlying cause given in Pert I.  25c. Was case referred to medical seathing in the underlying cause given in Pert I.  25c. Was case referred to medical seathing in the underlying cause given in Pert I.  25c. Was case referred to medical seathing in the underlying cause given in Pert I.  25c. Was case referred to medical seathing in the underlying cause given in Pert I.  25c. Was case referred to medical seathing in the underlying cause given in Pert I.  25c. Was case referred to medical seathing in the underlying cause given in Pert I.  25c. Place of beath (Check only gee)  25c. Was case referred to medical seathing in the underlying cause given in Pert I.  25c. Place of beath (Check only gee)  25c. Was case referred to medical seathing in the underlying cause given in Pert I.  25c. Place of beath (Check only gee)  25c. Describe how injury occurred in the time, date and place, and due	ritant	21. Signature of Funerel Service Licentus 22. Name and Address of Facility									-	- 10.0
23a. Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Bawe Shock, or heart failure. List only one cause on each line.    Due to (or as a consequence ot):   Due to (or as a consequence ot):	200		1011	26-11	I	icCully-	Polyni	lak F				
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27. Manyer of Death 2   Accident   2   ER/Outpatient   3   DOA   4   Nursing Home   2   Hesidence   8   Other (Specify)   28a. Date of Injury   28b. Time of Injury   Work?   1   Yes   2   No   28b. Time of Injury   Work?   1   Yes   2   No   28c. Injury at   Yes   2   No   2   No   28c. Injury at   Yes   2   No	tor, p	2 2	5. Was case referred to medical				26. Plac	ce of Deat				
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29a. Certifier (Check only one)  29a. Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred et the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	= 0			28a. Date of Injury (Month, Day Year)		28c. I	njury at Work?		28d. Describe ho	w injury occur	red	
29a. Certifier (Check only one)  29a. Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred et the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	or: A the fu		2 ☐ Accident Investigation			M	1 Yes 2					
29a. Certifier (Check only one)  29a. Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred et the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	irect n by		datarminad	28e. Place of Injury - At he building, etc. (Specify	me, farm, st ')	reet, factory, offi	ice				er or Rui	al Route Numbe
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Date signed (Month, Day, Year)	Funeral Ditely filled		(Check only 2 Medical Exami	ner: On the basis of examinat								
39. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Way & God at Tank 1 785 Ag Colon TRail (Flac Burnis Gazzia)	thin the maple			and manner stated.		29c. Lie	ense number		25	9d. Date signe	d (Month	Day, Year)
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Wayer Golf To Man 785 Ag Color Teal Glas Burne Me 2100	N	-	a second	or yang	020) (7:	Doing)	2//	> 0		, ) (	10/	
	1	1	y. Name and address of person who co	ompleted cabes or death (Item	7 8 T	A9 (	-a6	TI	2/6/	ea Bur	400	402106
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DHMH 16 Rev 6/95

Registrar

PHILIP STEVENS

OCT 1 8 2000



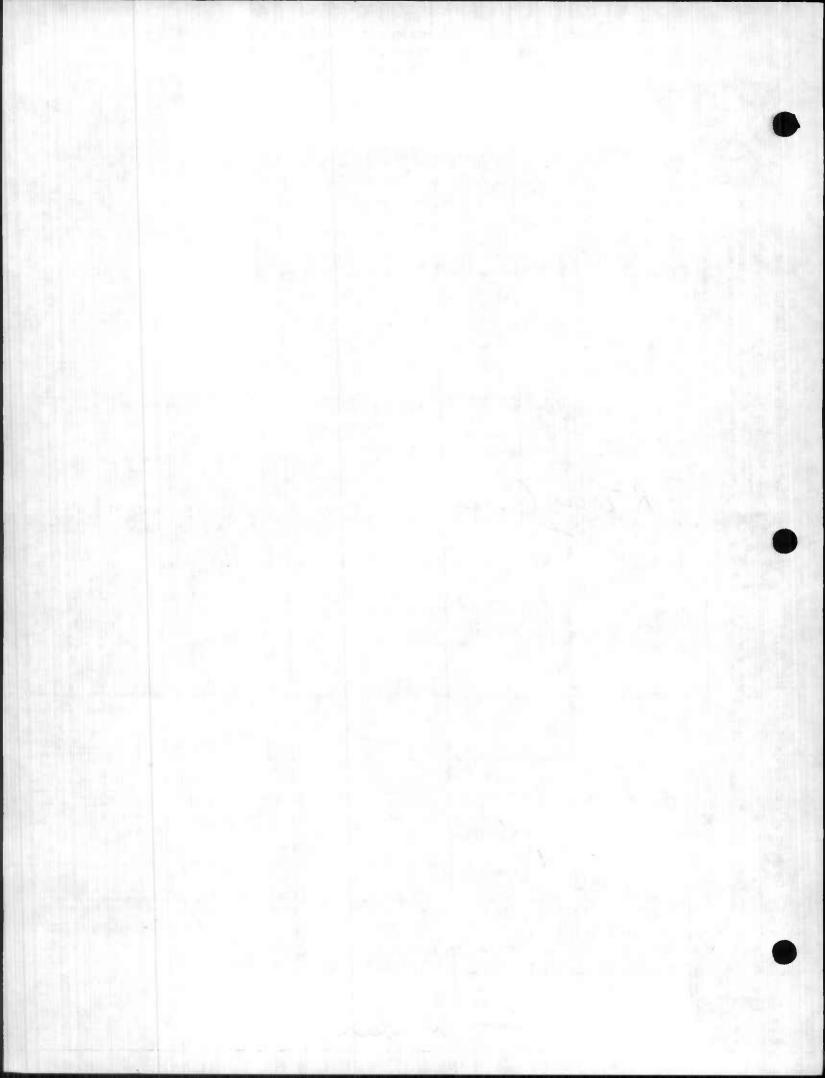
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		State of Marylan		artment of h		nd Mental	Hygiene (	3	2963
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/Medical Examiner	4a Facility Nama (If not institution, giva		00010		4b. City, Tow	vn, or Location of C			
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Funeral	121 Riverside 5. Social Security Number 6. Se	x 7. Aga (In yrs.	last birthday)	If Undar 1 Yaar	If Under 2		f Birth b, Day, Year)		laca (Stata or Foreign try)
Director	218-03-9579	DM 2□F 90	Yrs.	Months Days	Hours	Min. (Mont/ May	23 1910	Mary	
70	Usual Residence of Decedent				1				
rytun how Lat	10a. Stata 10b. County		y, Town or Lo					10	Od. Inside City Limits
o Ma	MD Baltim	ore		Ess	ex				1 ☐ Yas 2 ☑ No
or 28s-fr or 28s-fr be notifie Directo	10e. Street and Number			10f. Zip Coda			10g. Citizan of V	Vhat Coun	try?
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	1. Jury	Cornell	y,				more MD. 2		
	23a. Part1. Entar tha disaasa, or combi shock, or haart failura. List collection	cations that caused the death in cause on each line.	1. Do not sin	ter tha mode of dyi	ing, such as c	cardiac or respirato	ory arrest,		Approximate Interval Between Onset and Death
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led in by the funera Certification:	4 ☐ Homicida determined	building, etc. (Specify	/)	adi, actory, onice		City o	r Town, State)	. Sr or riura	Taribal (
S S	29a. Cartifiar 1 Certifying Phys	ician: To the best of my know	wiedne dest	h occurred at the ti	ime, date and	place and due to	the causa(s) and me	annar as si	ated
mpetely filled i	(Check only 2 Medical Examinations)	ner: On the best of my knowner: On the basis of axaminal and manner stated.	tion and/or in	vastigation, in my	opinion, death	h occurred at the t	ime, date and place,	and due to	the cause(s)
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7(1)	b To MA	To / A LL	// )	4 MI	ACE ,	AUP. B	ALTA.	MI	2 21221
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Registrar

DHMH 16 Rev 6/95

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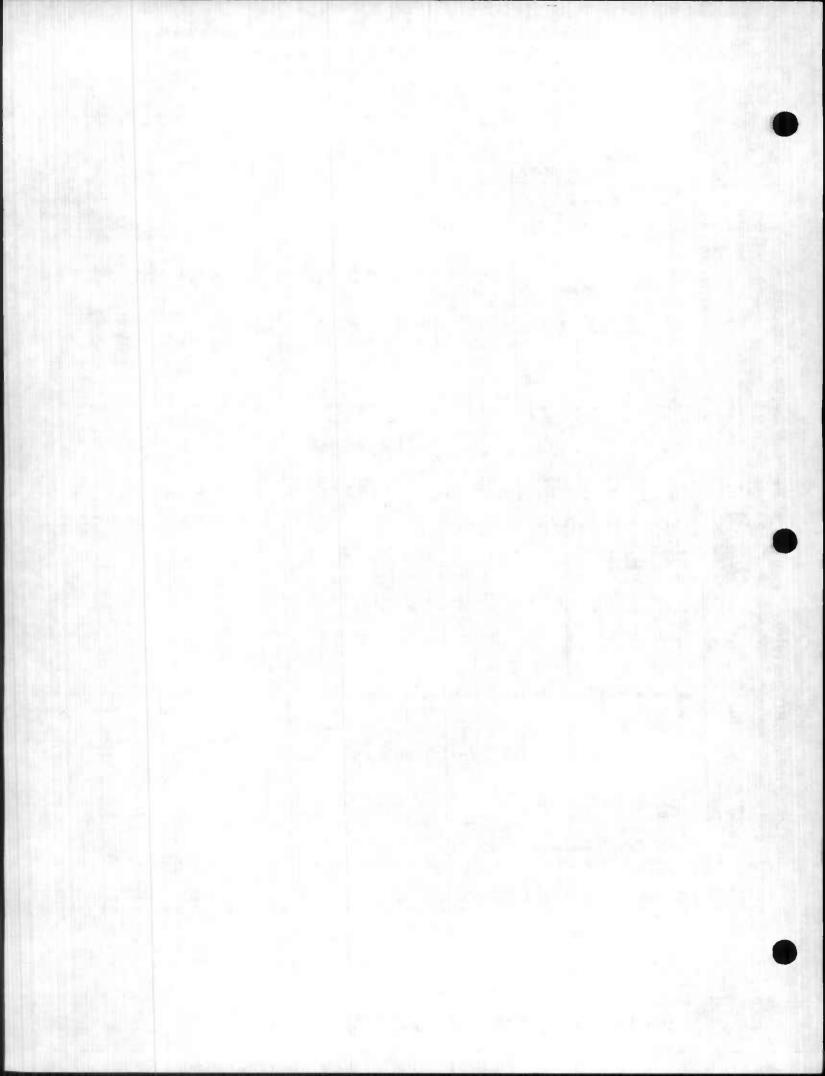
### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

		State of Mar	•	epartment of learning of learning of			ene Og. No.	0 32964
D	1. Decedent's Name (First, Middle, Last	1)				2. Date of Deeth Month	Day	3. Tima of Death
Physician /Medical Examiner	Jack C Shaffer 48 Facility Nama (If not institution, give				4b. City, Town, or l	October		00 16:30
Funeral Director	Anne Arundel Gener  5. Social Security Number  180–28–7108  Uaual Residance of Decedant		1 In yrs. last birtho	Months Days				runde1  9. Birthplace (Stata or Foraign Country)  PA
enyland ahow date	10a. Stata 10b. County		Oc. City, Town o					10d. Inside City Limits
vith the Me or 28s-f a	PA Lycomin	g	Cogan Si			•0	a Citizen of 16	
with with				10f. Zip Coda		10	g. Citizan of W	nat Country?
era era	223 Chaapel Mounta	.1n KD 12. Was Decedent Ev	ar in U.S.	177		pecify Yes or No-	USA 14. Race	- American Indien,
To should be filed within 72 hours after death with the Meryland death and Menella Hyglene.  I is marked other than "natural", or items 23s or 28s-f show traumatic avent, the trained Examiner man be notified at To Be Completed by Funeral Director.	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forcas?  1 ⊠Yes 2 □ No If Yas, Giva Year or Detes:		Was Decedant of If Yes, specify Cub     □ Yas 2 No		o Rican, etc.)		c, Whita, atc.
thou should be			16a. De	ecedant's Uaual Occu	pation	1	6b. Kind of Bu	White sinass/Industry
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be file d other avant.	17. Fathar's Name (First, Middle, Last)					na (First, Middla, M		
should be	Jesse C. Shaffer				Caroly	n Coffey		
Mally identice A I A I D-00 Co.  2 should be filed within 72 hours of  12 should be filed within 72 hours of  12 marked other than "natural", or  Traumatic avant, the little and  To Be Completed by F	19a. Informant's Name/Relationship (T)			ailing Addrass (Straa				
CENL	Myrna Jane Shaffer				lountain F			n, PA 17728
2 2 2 2 2	20a. Mathod of Disposition  1 M Buriel 2 Cramation 3 F  4 Donation 5 Other (Specify)		cematary,	sposition (Nama of cramatory or other pla n Cemetery	ace)	Data 2 10/18/00 1		TWP, PA
pemit. Peg Department Important: h any injury o	21. Signature of Funeral Service Licens	Todack.		22. Name end Addr Sterling A	shton Sch			
Physician	23a. Part1. Entar tha diseasa, or compi shock, or haart failura. List only o	lications thet caused the na causa on each line.	a daath. Do not	736 Edmond antar tha moda of dy				Approximete Interval Between Onsat and Death
/Medical Examiner	Immediate Ceuse (Final disease or condition rasulting in death)	8.		al Infarct	ion			Minutes
je le			ue to (or aa a cor					
be executed icien and burial-transit	Sequentially list conditions, if any, leeding to immediata ceusa. Entar Undarlying Cause (Disaase or Injury	0.	Ja to (or as a cor	ic Heart D	isease	10.29		
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w requir been s should						24a. Was an perform	autopsy ed?	24b. Wera autopsy findings available prior to completion of cause of death?
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entificat sctor, p	25. Was casa raferred to medical				26. Place of Dec	eth (Check only one		
Physician: The lar this certificate has rail director, page 2	axaminar?	Hospital: 1 Inpatient	2 ER/Outpe	etient 3 DOA	thar:	loma 5 ☐ Rasidar		r (Specify)
Ahanding Ph octor: After thi by the funeral	27. Mannar of Death  1 Netural 5 Pending 2 Accident investigation	28a. Deta of Injury (Month, Day Y	(ear) 28b. Tim	ry Wo	ury at ork? ] Yas 2 □ No	28d. Dascribe ho	w injury occurr	bed
bal or Attending P is after death. In Director: After led in by the funers Certification:	3 Suicide 6 Could not be 4 Homloida detarmined	28e. Place of Injury building, etc. (	- At home, farm (Specify)	street, factory, office		28f. Location (Str. City or Town,	eet end Numbe Steta)	er or Rural Route Number,
To the Hospital within 24 hours to the Funeral particletsly filled	29a. Cartifiar (Check only one)  1 Certifying Physical Cartification (Check only one)	eician: To the best of r ner: On the basis of an and mannar state	camination and/o	eath occurred at the trinvastigation, in my	ima, data and place opinion, daeth occu	e, and dua to tha ca urred at tha tima, da	usa(s) and ma ta and place, s	nner as stated. ind due to the causa(s)
To a series	29b. Signature and little of codilion	20	No	29c. Licen	se number 060		d. Data signed	(Month, Dey, Year)
.SV	30. Nama and addrass of person who or	ompleted causa of dae	th (Item 23a) (Ty	pe, Print)				
State	William P. Jones, 31. Data filed (Month, Day, Year)	MD 695 Am 32. Ragistrar's	erica Co Signatura	ourt Sha	adyside,	MD 21035		

DHMH 16 Rev 6/95

Registrar

Sparks



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middla, Last) 3. Tima of Death 2. Data of Death Dey Yaar **Physician** SARAH OCFOBER 13, 2000 exation of Death 4c. Obunty of Death 9:00 PM ANN SMITH /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UOSEPH / 5. Social Security Number RITCHIE HOSPICE CARE BALTIMORE If Under 1 Ye Months Da f Under 24 Hrs. Hours | Min. 6. Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days 10 M 25 F Hours Director 217-66-6440 Usual Rasidance of Decedant 10a Steta 10b. County 10c. City, Town or Location 10d. insida City Limits show r than "natural", or items 23a or 28a-f short the Wedical Examiner must be notified at 1 165 2 No Director DUNDALK MO BALEIMO RE arah A. Smith 10-13-00 timore, Maryland 21215-0020 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 2910 22 12 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) Was Decedent Ever In U.S. Armed Forcas? 1 Yas 2 No If Yes, Giva Yaar or Datas: 11. Marital Status 14. Raca - American Indian, Black, White, atc. 1 Nevar Married 2 Merried 1 Yas 2 No Specify: Specify: BLACK p 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOUSE WIFE 12 HOMEMBRER marked other 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Heelth and Mental 2 HOW ARD 5mIth MAE DOUGLAS 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 20b. Place of Disposition (Nama of carmatary, cramatory or other place) Data 20c. Location - City or Town, State Department of Heelth mportant: If Item 27 IAMERIA WILLIS altimore, 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovai from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY INCIO-17-00 BALLIMIKE, MD 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility HOWELL FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 23a Part I finer the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac of respiralory arrast, ahock, dr.haart failure. List only one cause on each line. Approximata Intarvai Batween Onset and Death **Physician** /Medical immediata Cause (Final 3 Weaks Hop Skulycosis OF SINUSES a. INVASIVE diseasa or condition rasulting in daath) Examiner Dua to (or as a consequence of) AIDS YERMS Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last 80 Dua to (or as a consequence of): 68760 physician Physician/Medical 2 Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown rigned by ğ 2 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No Division of Vital 25. Was casa rafarred to medical axaminar? 8 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Sthar (Specify) HospicE 2 1 Yas 2 TNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 결 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Aftar 5 Panding invastigation 1 ONatural death. 1 ☐ Yas 2 ☐ No 2 Accident after death Director: 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital eithin 24 hours a Ta the Funeral C completely filled Hospital M hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Cartifian 296 Signatura and titia of certifier 29c. License number 29d. Data signed (Month, Day, Year) unaufother MD 06933 John

State Registrar

DHMH 16 Rsv 6/95

31. Date filed (Month, Day, Year)

JOHN B MACGIBBON

32. Registrar's Signature

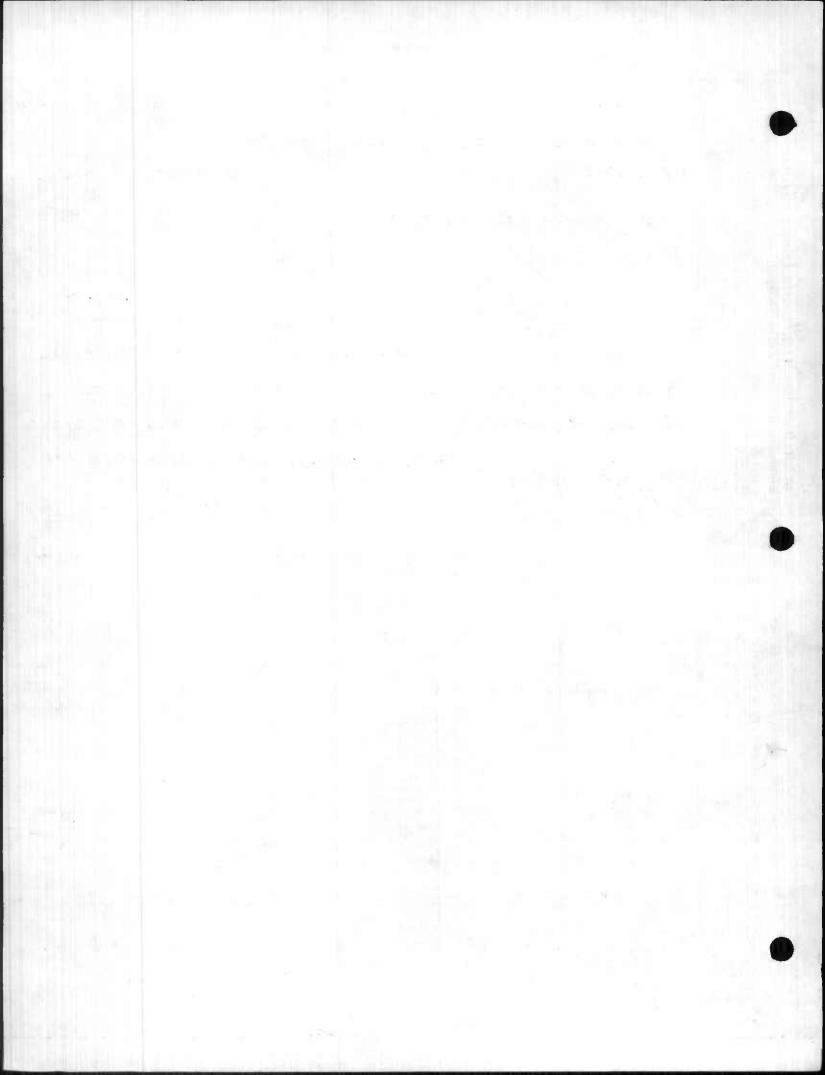
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30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

SUITE 39

10/16/00

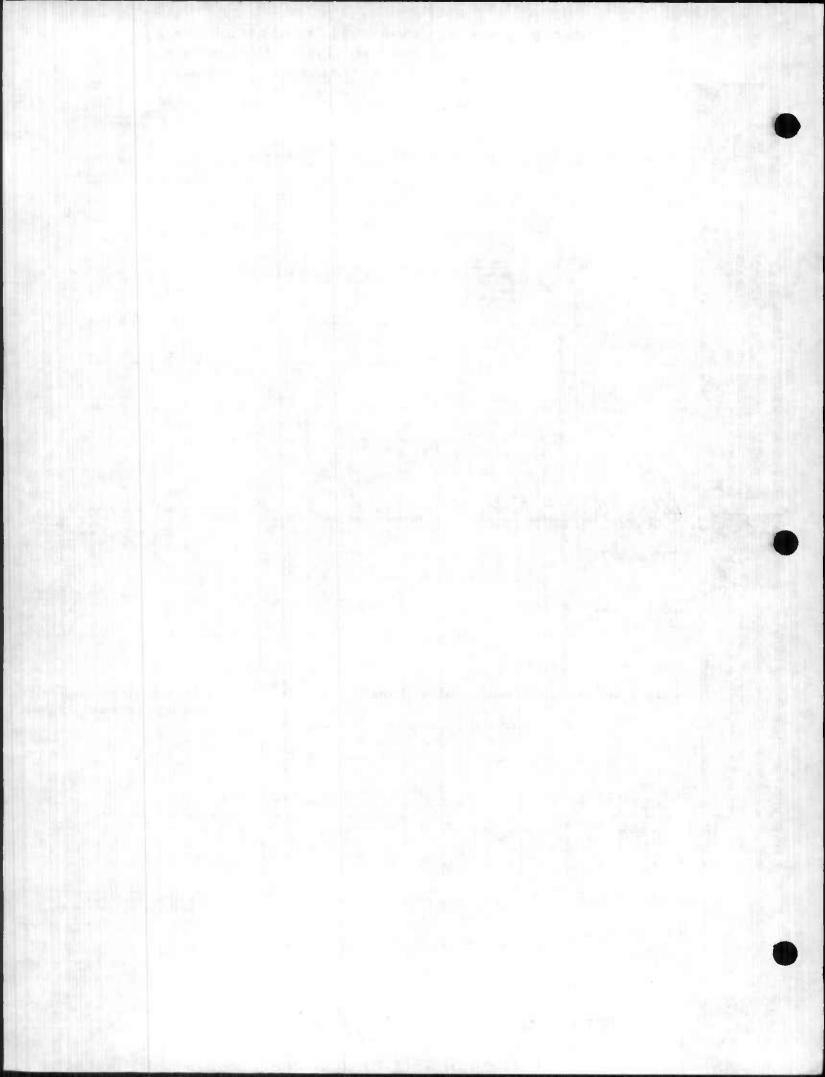
BALTIMORE



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		State of Maryland	Certificate of	Death	Reg. No.	00 3	2966
Physician /Medical		3. Sturd		oč	ate of Death Monthy Day	2000	3. Time of Death 6.30 AH
xaminer ineral	4a Facility Name (If not institution, give s GOOD SAMARITA  5. Sociel Security Number 212-03-4233  6. Sex	AN NURSING H	IOME	Hours Min. (A	ete of Birth Month, Dey, Yeer)	N/A  9. Birthple Count	ace (Stete or Foreign ny) "HCAROLIN
	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location	I IME	1 30,191		d. Inside City Limits
Funeral Director	MARYLAND N/A  10e. Street and Number  4300 FOREST PAF		ALTIMORE  10f. Zip Code 21	207		of What Count	1 □Xes 2 □ No
by Funeral		2. Wes Decedent Ever in U,S Armed Forces? 1 _ Yes _2 No If Yes, Give X Yeer or Detes:	i. 13. Was Decedent of I	Hispenic Origin? (Specify Yan, Mexican, Puerto Rican	Yes or No- 14.	Race - America Black, White, e O - AME F	tc.
Completed	15. Decedent's Educ (Specify only highest grade Elementery/Secondary (0-12) 6 TH 17. Father's Neme (First, Middle, Last)		16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use relire MACHINE OPE	during most of working id)	WEST		ECTRIC
To Be	WILLIAM BRYANT  19a. Informant's Name/Relationship (Type		19b. Meiling Address (Stree	ANNIE			Code)
	WILBERT STURDING  20a. Method of Disposition  1 Burlal 2 Cremation 3 Re 4 Donation 5 Other (Specify)  21. Separature of Funeral Service License	emoval from State  CRYPT  20b. Ple	J) 4231 NORF see of Disposition (Neme of metery, cremetory or other ple OODLAWN CEME 22. Name and Address	TERY OCT.	20c. Loca 19,2000	BALTO	vn, State
DUCE C	Pent. Enter the disease, or complic shock, or heart failure. List only on	petions that ceused the death.	1412 E.	PRESTON ST	BALTO.	MD. 21	213 Approximete Interval Between Onset and Death
dicai Examiner	Immediate Cause (Final disease or condition resulting In deeth) a.	Due to (or	as a consequence of):			1	lers Than 2 WKS
Medicai Examiner	Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or	as a consequence of): as a consequence of):				ZUKS
Physician/M	Part II. Other significant conditions cont	ributing to death but not resul	ting In the underlying ceuse g	iven in Part I.			the cause of death?
Completed by					24a. Was an autopsy performed?	ava	re autopsy findings illable prior to npletion of cause leeth?
Be Comp	25. Was cese referred to medical			28. Place of Death (Ch	1 ☐ Yes 2 00		Yes 2 No
Certification: To E	27. Manner of Death 1 Ovaturel 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury 28c. Injury	ry at 28d. rk? ] Yes 2 □ No 28f. I	5 Residence 8 Describe how injury of the Location (Street and	occurred	
edical	29a. Certifier 1 Certifying Physi	building, etc. (Specify)	riedge, deeth occurred at the ton and/or investigation, in my	ime, date end place, and d	City or Town, State)	nd manner es st	ated.
M M	29b. Signature and title of certifier	K. Trupe	D D	30661	octo	signed (Month, I	Dey, Year) (C 2000
State	30. Name and editors of person who cor 560   Dolly Raw 31. Date filed (Month, Dey, Year)	32. Registrar's Signatu	Baltuore.	Rd - 21	239	2,0	

ORIGINAL

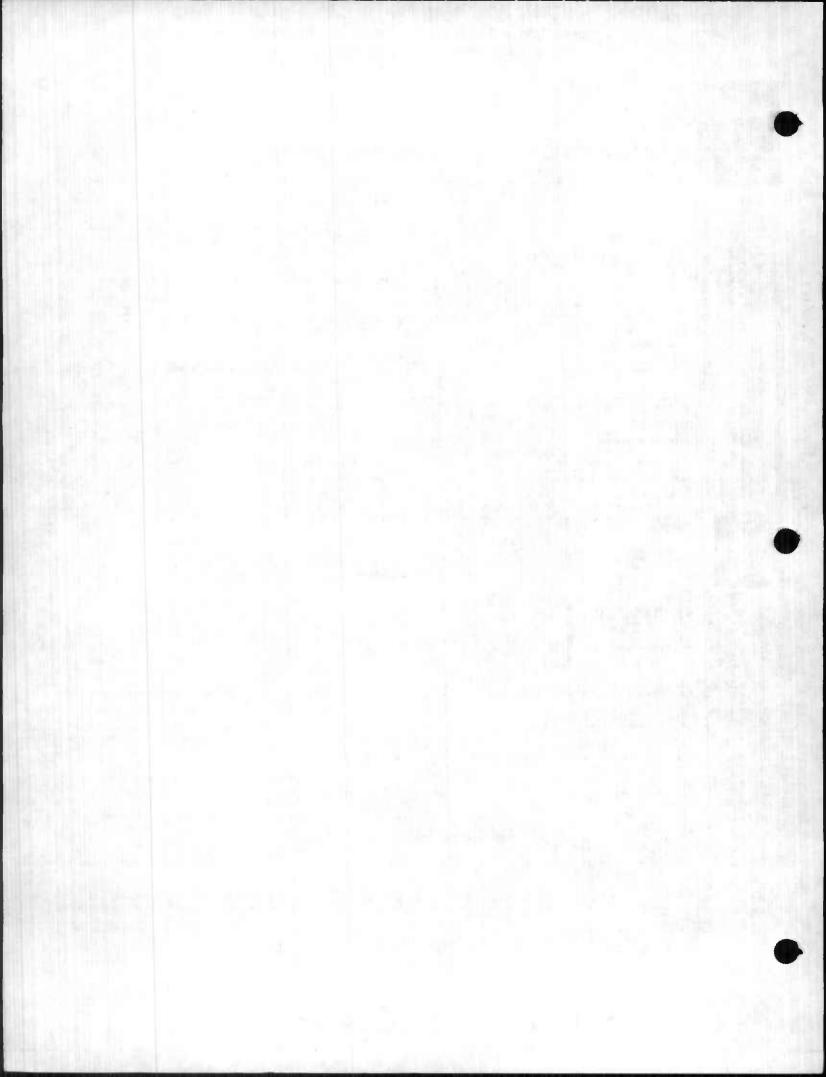


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	State of Maryland / Department of Health and N Certificate of Death		giene       Reg. No.	32967
Dhuaisian	1. Decedent's Name (First, Middle, Last)	2. Date of De Month		3. Tima of Death Year
Physician /Medical	ROBERT IRVIN TYRRELL	Octob		0000 5:30am
Examiner	4a Fecility Name (If not institution, give street end number)  4b. City, Town, or L			
	Greater Baltimore Medical Center Towson		D = 7 +	/
° Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Ars.	8. Date of Bir	Balt.	9. Birthplace (State or Foreign Country)
Director	136-01-9013 12M 2 F 91 Yrs. Months Days Hours Min.	8. Date of Bir (Month, De Sept.	1909	New Jersey
2	Uaual Residence of Decedent			
rytar hose	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
of the cto	Maryland Baltimore Baltimore			1 ☐ Yes 2 XNo
tre and	10e. Street and Number 10f. Zip Code		10g. Citizen of W	hat Country?
at at a	6451 N. Charles Street Apt. 206 21212		U.	S.A.
ritems 23s or 28s-f showning the control of the con	11. Manital Status 12. Was Decedent Ever in U,S. 13. Was Decedent of Hispanic Origin? (Sp. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. Armed Forces?)	pecify Yes or No	- 14. Race	- American Indian,
大百 1	1 Never Married 2 Married 1 X Yes 2 No	o rilican, etc.)		, White, etc.
5	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates: WW II 1□ Yes 2 XNo Specify:		Specify:	White
ted fa	15. Decedent's Education 16a. Decedent's Usual Occupation	le les es	16b. Kind of Bus	siness/Industry
r, the Medical	(Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)  (Give kind of work done during most of work life. DO NOT use retired)	any .		
# E	12 years District General Manage	er	Insurar	nce
Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name	ne (First, Middle	Maiden Sumeme	)
ToB	James Tyrrell Ella		unk.	
-	19a. informant's Name/Relationship (Type, Print)  19b. Meiling Address (Street end Number or Rus	ral Route Numb	er, City or Town, S	Stete, Zip Code)
in the	Judy Leutner (niece) 3202 Allness Lane Oak	Hill. V	/irginia	20171
offin	20a. Method of Disposition  20b. Place of Disposition (Name of cametary, crametory or other place)	Date		City or Town, State
to A	I Dunal 2 Dicternation 3 Directional from State	0-17-00	Rol+i-	one Manufand
1	4 Donation 5 Other (Specify) Green Mount Crematory 1  21. Signature of Funeral Service Licensee 22. Name and Address of Facility	.U-17-UQ	Daltill	ore, Maryland
once	Mitchell-Wiedefeld	Funera	1 Home.	Inc.
900	Ceorge & Ferrane 6500 York Road Ba	1timore	, Maryla	nd 21212
-	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart fallure. List only one cause on each line.	or respiratory a	rrest,	Approximete interval Between
sician				Onset and Death
dical niner	Immediate Cause (Final disease or condition a. // / / / / / / / / / / / / / / / / /	7		2 Weeks
	Due to (or as a consequence of):			
in in				
the burial-transit	Sequentially list conditions,  Due to (or as a consequence of):			
E E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.			
E E	that initiated events resulting in death) Last  Due to (or as a consequence of):			
2 4				P4 54 H 1/15/11
or use	G			
10	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did	tobacco use conf	tribute to the cause of death?
Physician/M		10	Yee 25 No	3 Probably 4 Unknown
be cetached by Physic				
			en eutopsy	24b. Were autopsy findings
Completed		perfo	ormed?	available prior to completion of ceuse of death?
Q.				
		10	Yes 2 No	1 ☐ Yes 2 ☐ No
Be	25. Was cese referred to medical exeminer?	th (Check only	one)	
			dence 6 Othe	
OD:	27. Menner of Death 1 ☑ Neturel 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?	28d. Describe	how injury occurre	bd
d in by the funeral	2 Accident investigation M 1 Yes 2 No			
led in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location ( City or To		or Aurel Route Number,
Ce				
Medical Cert	29a. Certifier t⊠ Certifying Phyeiclan: To the best of my knowledge, deeth occurred at the time, dete and place, (Check only 2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occur			
Medical	and manner stated.		cate and place, 6	no due to the cause(s)
2	29b. Signature and title of perfitier 29c. License number	1		(Month, Dey, Year)
^	Prot Rekha Motag: M.D. D5299.	+	10-12	+-2000
1)	30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)			
10	Retha Motage GBMC 6701 N. charles St. B	Baltin	role M	0 21204
State	31. Date filed (Month, Dey, Year)  32. Registrar's Signature			
State legistrar	DOT 1 9 2000 Degree & Spark			
	CALLED CHAIL AND TO THE BALLET AN			

ORIGINAL

Tyrrell, Robert Irvin



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Month eahmiah Teasdell 7:25 AM October 2000 4e. Facility Name (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Death ended Boltmore
If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Dey, Year) VAMC Rehab | Extended

6. Sex | 7. Age (In yrs. lest birthday) | If Under 1 Yes

Months | Da Baltimore 5. Social Security Number 9. Birthplace (State or Foreign 140 M 20 F 260-20-3079 Usual Residence of Decedent 10a. Stat 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No 10e. Street and Number 10g. Citizen of What Country? 2 2122 Was Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Merried ☐ Yes 2☐ No f Yes, Give 1 Yes 2 No it Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 1ack 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) Benjamin Ihigfen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number; Lity or Town, Stete, Zip Code) 2122 10. 20b. Place of Disposition (Name of cemetery, cremetory or other place) wife 20e. Method of Disposition Date 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) leteran Cemetery 21. Signature of Funeral Service Lice 22. Name end Address of Facility 1/ens 23a. Part Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock, othern failure. List only one ceuse on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as e consequença of) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ triknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Anatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Piaca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide

ettanding physician and for use es the burial-transit Box 68760. Division of Vital Records, P.O. peen s or Attending Physician:

Examiner Physician/Medical by Completed Certification:

**Physician** 

/Medical

**Examiner** 

Director

Funeral

þ

Completed

Be

Director

itam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinat must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hyglene. Important: if fam 27 is marked other than "natural", or items 28s any injury or other traumstic avant

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

with the Manylend

24 hours after death.

Funeral Director: After Hospital To the F within 2

> State Registrar

Medical

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

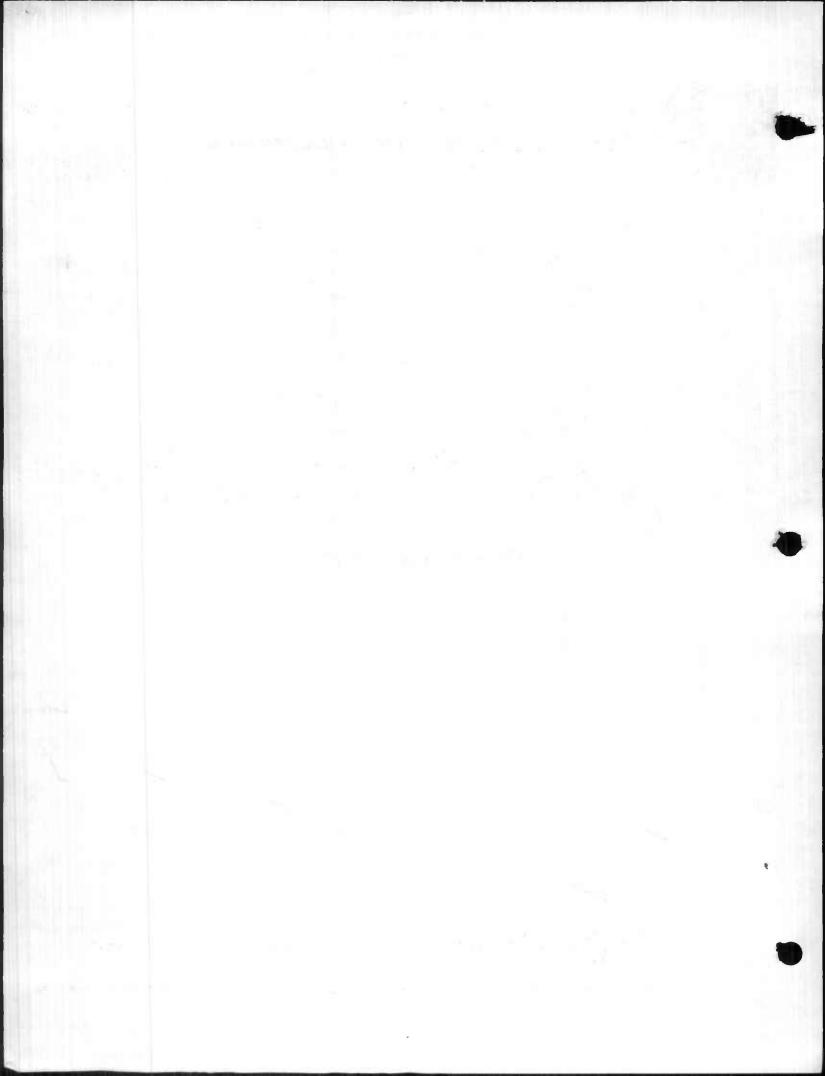
who completed cause of death (Item 23e) (Type, Print)

M.D 32. Registrar's Signature

29a. Certifier

(Check only one)

2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2000 Marie W. Vacchiano October 11 14:50 P.M. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street end number) Examiner Harford Memorial Hospital Havre-De-Grace Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** 1□ M 20€F Days Months Hours Yrs. Director 142-07-9956 83 01/04/1917 NJ Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director 28a-f MD Harford Havre-De-Grace 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Вета 23а 21078 USA 415 South Market Street Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 14. Race - American Indien, Black, White, etc. 1 ☐ Never Merried 2 ☐ Married "natural", or 1 Yes 2 No Specify: Specify. by 3 MWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry flied within 7. Hyglene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be 1 and Mental 9 is marked of Oliver Van Note Edna (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Nem 27 is Julie Groner Daughter 106 Whittier Road Brick NJ 08724 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Calvary Cemetery 10/14 Neptune, NJ 21. Signature of Funeral Service Licensee Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart language unit only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequença of) Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably Wunknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes A No Inpatient 2 ER/Outpalient 3 DOA 28a. Date of tnjury (Month, Day Year) 27. Manner of Death Certification: Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide ğ 6 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the Ha within 24 t 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wind 31. Dete filed (Month, Day, Year) 32. Registrer's Signature

**DHMH 16 Rev 6/95** 

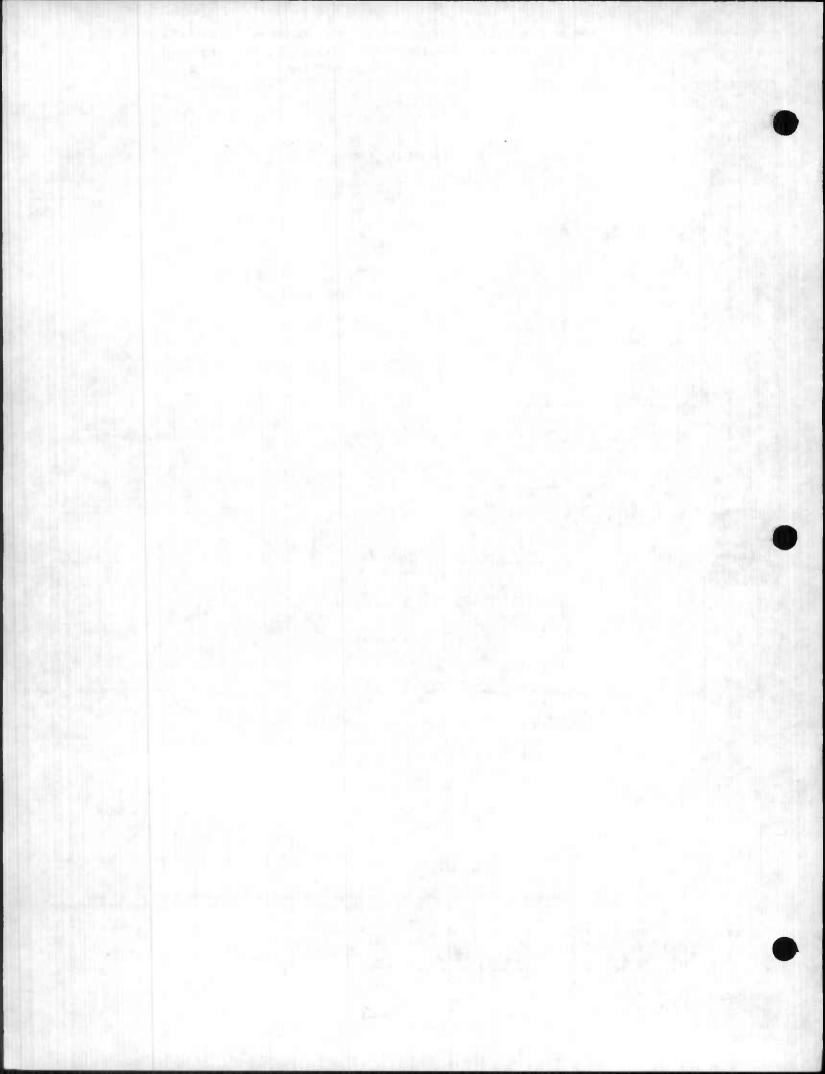
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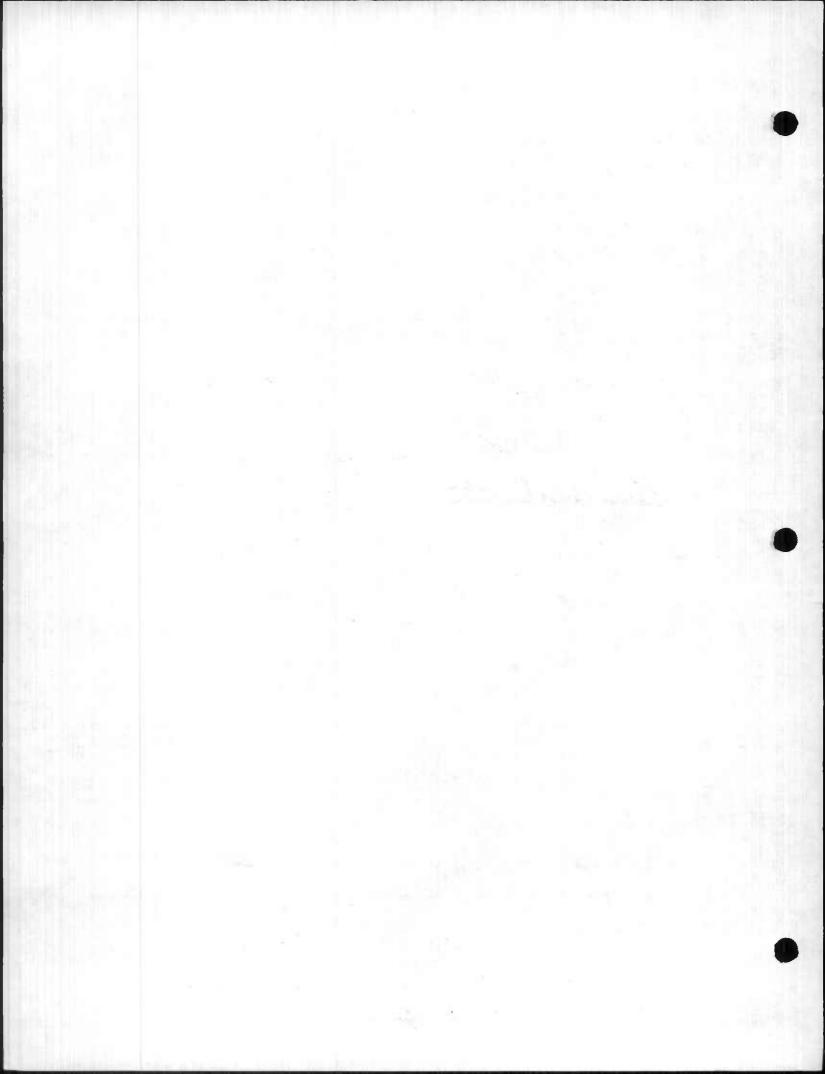
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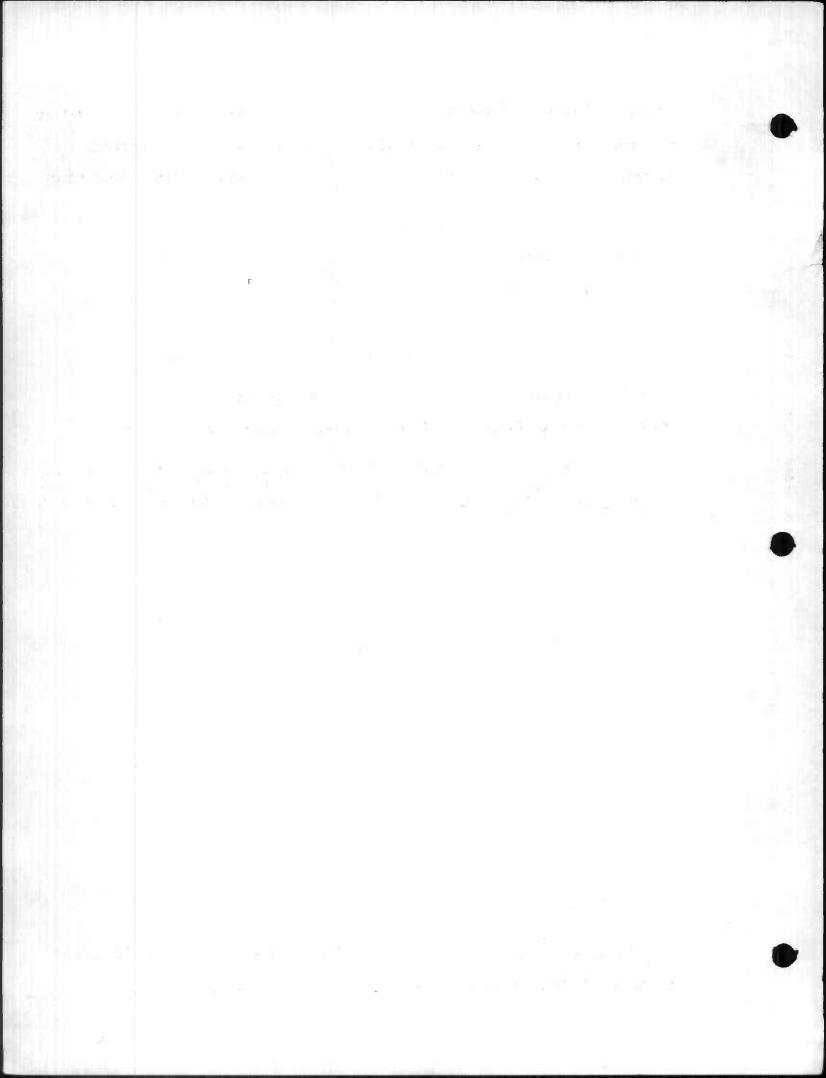
State of Maryland / Department of Health and Mental Hygiene

				Cei	rtificate of	Death		Reg. No.	U	2910
	1. Decedent's Neme (First, Middl	e, Last)					2. Dete of E		Mana	3. Time of Deeth
Physician	Jean			Wortha	m		Month	er 15, 2	O00	2 DM
/Medical Examiner	4a Facility Name (If not institution	n, give street and n	rumber)	WOL CITA	111	4b. City, To	wn, or Location of De		y of Death	2 PM
Examiner	1312 Appleby					Balti	imore		/A	
	5. Social Security Number	6. Sex	7 Age (In ye	s. last birthday)	If Under 1 Year	and the second	24 Hrs.   9 Date of B	tieth		lace (State or Foreign
Funeral	214-24-3648	1□M 2√F	67	Yrs.	Months Days		Min. (Month, I	lay, Year)	Maryla	(IV)
Director	Usual Residence of Decedent	21	0,				рерс	3,1333	PICIL Y LC	and .
3 1	10a. State 10b. County		10c. C	City, Town or Lo	cation				10	0d. Inside City Limits
tany of all and	Marriand M/	7	D	-1+						No Yes 2 No
or 28a-f. be notified Directo	Maryland N/	A	Ь	altimor	1				140 40	Λ
oth with the Maryla 23e or 28e-f sho ust be notified at rai Director	10e. Street and Number	7			10f. Zip Code	1200		10g. Citizen of		try?
6 KH E	1312 Appleby					1209		US	4	
fer death v fleer death v floer must funeral	11. Marital Status	12. Was De Armed F	cedent Ever in Forces?	U,S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Ori an, Mexicar	igin? (Specify Yes or it n, Puerto Rican, etc.)		ce - America	
O all all		H Ven G	2X No		1□Yes 2√√No	Specify:		Specif		
hours after hours after hours, or h at Examina od by Fu		Year or	Dates:		XX			Opecin	y. WIII	ite
21215-0 ed within 72 ho ygiene. we then 'natur 4, the Medical.  Completed	15. Deceden (Specify only higher	t's Education	1)	16a. Dece	dent's Usuel Occup kind of work done	pation during mos	t of working	16b. Kind of B	Jusiness/Ind	lustry
21215-0020 within 72 hours at glens. Then "natural", or the Medical Exams Completed by F	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retire	id)				
	12				Homemak	er		Ow	n Home	е
Be day	17. Father's Neme (First, Middle,	,					er's Name (First, Midd		m <i>e)</i>	
/la	Nelson Caltwr	laer				Chi	ristina Pa	7T		
Maryland d 2 should be fise in and Mental Hy 7 is merited othe traumatic event	19a. Informant's Name/Relations Thomas Wortham	hip (Type, Print)	ATTE	19b. Meilir	ng Address (Street	end Numbe	er or Rural Route Num	ber, City or Town	, State, Zip	Code)
Z 25 Z	Thomas Wortham	Son		7523	Bayfron	t Road	d, Baltimo	re, Mary	Land 2	21219
D - T E E	20a. Method of Disposition		20b.	Place of Dispo	sition (Name of		Dete	20c. Location	- City or To	wn, State
timori timent of ti	MXBurial 2 ☐ Cremation		n State W		netory or other ple Cemeter		10/18/	I STOOM OF	awn l	Maryland
The same	4 Donation 5 Other (S						1	JO MOODEL	uwii, 1	at y Land
Ball Beaming and	21. Signature of Funeral Service.	//	-	_ R	Name and Addre	nee-Se	itz Funer:	al Home	Tnc	21211
- 40240	23a. Part1. Enter the chicasa, or shock, or heart thillies. List	nos lay	Denlu	3	631 Fall:	s Road	d. Baltimor	re. Marv	land	21211
_	23a. Part1. Enter the disease, or shock, or heart thilure. List	complications that	caused the de	ath. Do not ent	er the mode of dyi	ng, such as	cardiac or respiratory	arrest,		Approximete Interval Between
Physician	0								1	Onset and Death
/Medical	Immediate Cause (Final disease or condition		Dro. C	000 (10	men Or	do	cident		1	Ham.
Examiner	resulting in death)	a		(or as a consec	104704000	^	Ciona		1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
je de la companya de			and	(or as a consec	D.C.	Sh			1	Vac
ansit		b		(or as a conseq	SOU FOIL	your	~~~		- 1	reus.
axec n an ial-tri	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		1	O J	No.	06/ =				1/ 0-
68760, fileate be as physician as the burial edical E	Cause (Disease or Injury that initiated events	c	Ma	Den	2	elli 3	rus -			rears-
x 68760, ertificate be assected ling physician and ie es the burial-transit Medical Examiner	resulting in death) Last		Due to	(or as a conseq	uence of):					
Certification of the see of the s		d							1	
deeth of deeth of attended for us									1	
S FF S	Part II. Other significant condition	ens contributing to	death but not re	sulting in the u	nderlying cause gi	ven in Part I	23b. DI	d tobacco use co	ontribute to	the cause of death?
that the sed by detac							10	Yes 2 No	3 Prob	bebly 4 Unknown
0 88 a									1	4.5
Records le law requires s has been sign ge 2 should be								s an autopsy formed?	ava	ere autopsy findings allable prior to
law re la							_		of c	mpletion of cause death?
The taw requirate has been spage 2 should							10	Yes 2 No	1.	Yes 2 No
Vital I	25. Was case referred to medical		-			00 01-				7168 20110
Vita	examiner?	Hospital:	24		Ott	hor	of Deeth (Check only			
Vision of Vital Rate and the standing Physician: The standard the sector: After this certificate haby the funeral director, page standard the sector.	1 Yes 2 No	28a. Date		☐ ER/Outpatier 28b. Time of	I 3LI DOA	4LINU	ursing Home 5 Re	sidence 6 LIOti s how injury occu		0
Division of the or attending P is after death.  a) Director: After the or in by the funers Certification:	1 Natural 5 ☐ Pendin	g (Mo	nth, Day Year)	tnjury	Wo	rk? IYes 2□		o now injury occu	1100	
VISION Attending or death. ector: After by the fune	2 Accident investig	not be				1 105 2		(0)		10
Division or Attending after death. Director: Afte d in by the fune.	4 ☐ Homicide determ	ined   288. Plec	se of Injury - At ding, etc. (Spec	home, term, str cify)	eet, factory, office			(Street end Num own, State)	ber or Hural	I Houte Number,
S S S S S										
he Hospin 24 hound in 24 hound	29a. Certifier 1 Commyin	g Physician: To the	e best of my kn	nowledge, death	occurred at the ti	me, date an	d place, and due to the	e cause(s) and m	anner as st	ated.
Divisio  To the Hospital or Attendit within 24 hours after death. To the Funeral Director: At Combining filled in by the fu	one)	anderfa	nrinr stated.	TOTAL MARKET HIS	Congation, army t	openion, usa	at the (IIII	, date and place,	, 5110 308 (0	04000(3)
A Market	29b. Signature and title of conflict	M	1	10	29c. Licens	-		29d. Date signe	ed (Month, I	Day, Year)
1X	1//	en!	Mn	rno	D	230	702	101	116/6	20
000	30. Name and address of person	who completed on	isa of death (the	em 23a) (Type,	Print)			/		-
1			ork Roa			Max-	land 21093			
	Phillip Mac, M 31. Date filed (Month, Day, Year)		Registrar's Sign		ier ATTT6	rial y	1anu 21093			
State Registrar	OCT 1 8 2000	here	L. J.		aks					
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State of Maryland / Department of Health and Mental Hygiene

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Physici		Charles N	latthe	ew Was	hingto	on			Month	Day	Year	
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Department of Heelth and Mentel Hygin Important: If Item 27 is marked other eny injury or other traumatic event, I once.	ToB	James M. Was	hinot	on				Helena	Rvers			
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alth a		Barbara W. Ba	rnwe1	1 /Sist	er	4014	Glen Ave	. Ralti	more, Maj	cyland 3	21215	
f He mother		20a. Method of Disposition			20b.	Place of Dispo	osition (Neme of metory or other pla	000	Date	20c. Location		State
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Woods NOREW 3.21 PM Oct. 4 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner BALTIMORE NIA OF MARYLAND MEDICAL System 7. Age (In yrs. last birthday) H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 18, NIUOUSIty 5. Social Security Number / Birthplace (State or Foreign Country) **Funeral** 1፟M 2□ F 212-34-6103 **Director** ILL Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland neal of Health and Mental Hyglene.
Int! If Item 27 Is marked other than "raturel", or Items 23s or 28s-f ahow any or other transmit or any or other transmit or notified at my or other transmits event, The Medical Example mant be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Baltimore 1X Yes 2 □ No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5116 Whitefield Avenue 21212 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? UNK 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white by 3 Widowed 4 Divorced Year or Dates: Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) +5 social worker education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) UMMS 22 S. Greene Street Baltimore, MD 21201 20b. Place of Disposition (Name of cametery, crematory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department 4 ☐ Donation 5 🛣 Other (Specify) in state 21, Signature of Foneral Service Licer Ronald S. 22. Name and Address of Facility
State Anatomy Board Wade 655 W. Baltimore Street Baltimore, MD 21201

23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, wheelt failure. List only one ceuse on each line. Med Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final \* Multi syskm OLGAN disease or condition resulting in death) Examiner Due to (or as a consequence of): Examine TAILURE physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): APPROVED BY MEDICAL EXAMINER CERTIFICATI Ad TN/URY Due to (or as a consequence of): P.O. Box 68760. Physician/Medical 88 USB P signed by the a 23b. Did tobacco use contributs to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 20 No 3 Probably 4 Unknown Division of Vital Records, g 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen certificate has b 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 28. Plece of Death (Check only one) examiner 1 Yes 2 No To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? To the Mospital or Attending Pi within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Certification: After 1 Natural 5 Pending investigation 1 Yes 2 No Collision Sept. 22, 2000 9:20 PM motor which 2 M Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5600 Alameda STREET BALTIMOLE 1M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

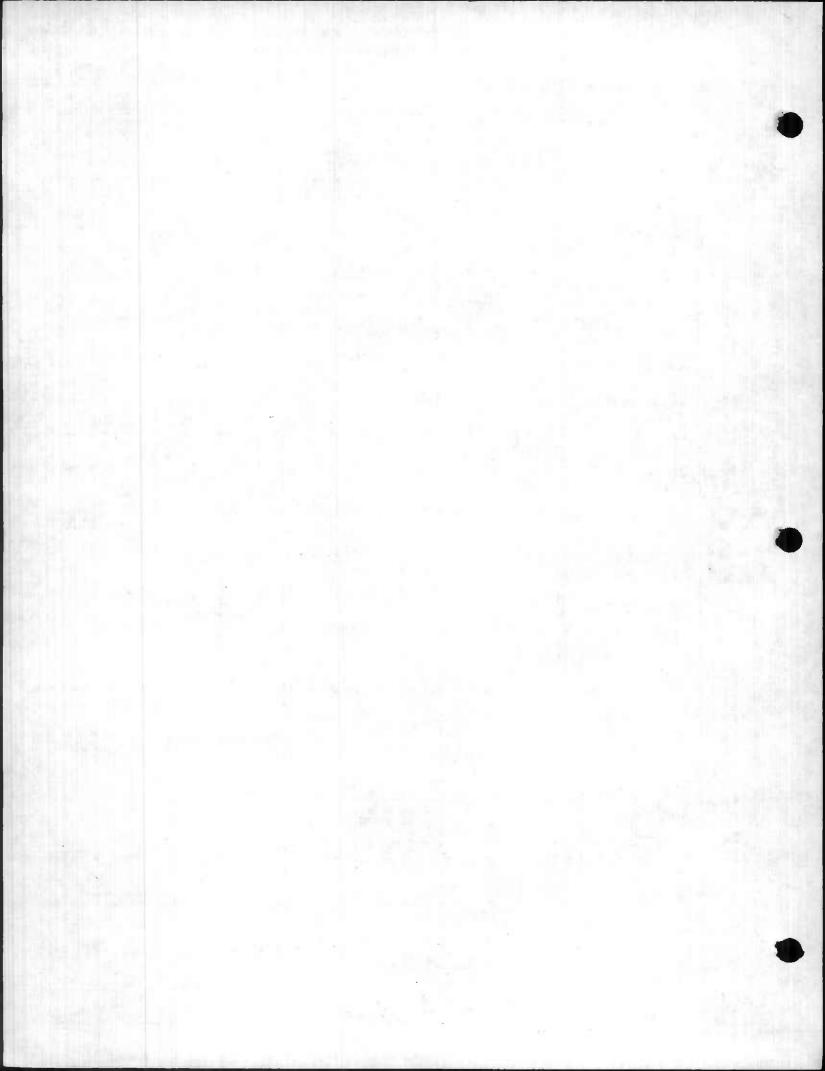
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner plated. 29a. Certifier Medical (Check only one) 29b. Signature and Mile of cedifier 29c. License number 29d. Date signed (Month, Day, Year) D005380 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN J. South South GREENE ST. BALTIMORE MD 21201 31. Date filed (Month, Day, Year)

State Registrar

OCT 1 8 2000

32. Registrar's Signatur

Sparks



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Day October 2000 12 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street end number) 4c. County of Death OSD more ff Undar 1 Yaar 8. Date of Birth Month, Dey 9 Birthplace (State or Foreign 5. Social Security Number 6. Sex 24-30-8299 Days Min 10 M 200 F Yrs North Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Maryland mor 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Ve 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race 12. Was Decedent Ever in U,S. Armed Forces? Amaricen Indian 11. Marilai Slalus Black, White, etc. 1 Yes 2 No If Yes, Give Yaar or Dalas: 1 Nevar Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced ear 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 18. Mothar's Name (First, Middle, Maiden Sumeme) 17. Falher's Name (First, Middla, Last) 19e, Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Balto.1 11/0 ohnnie 20b. Piace of Disposition (Name of cemetery, cremetory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 25/2000 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 □Other (Specify) emete 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Home uneral le Ba 21216 22 Ave. W. North 23a. Pan1. Enter the cheese, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock or heart filture. List only one cause on each line. Approximate tnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Yell. Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part ft, Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? age Reval Bisease 24a. Was en eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yas 25. Was cese referred to medicel exeminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 27. Menner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturat 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide

Box of Vital Records, To the Hospital or Attending Physician: Division

**Physician** 

/Medical

Examiner

**Funeral** 

Director

23a or 28a-f ahow

the Medical Examiner must be notified at

or Herna

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permit. Pegas 1 and 2 should be file Department of Health and Mental Hy Important: if Nem 27 is marked oth any Injury or other traumatic avent Pates.

Physician

/Medical

Physician/Medical Examiner

Be Completed by

Medical Certification: To

After

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within 24 hours of

completely

Examiner

Funeral Director

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Be Completed

filed within 72 hours efter death with the Maryland

Saitimore, Maryland 21215-0020

Registrar DHMH 16 Rev 6/95

31. Dala filed (Month, Dey, Year) State

29a. Certifier

(Check only one)

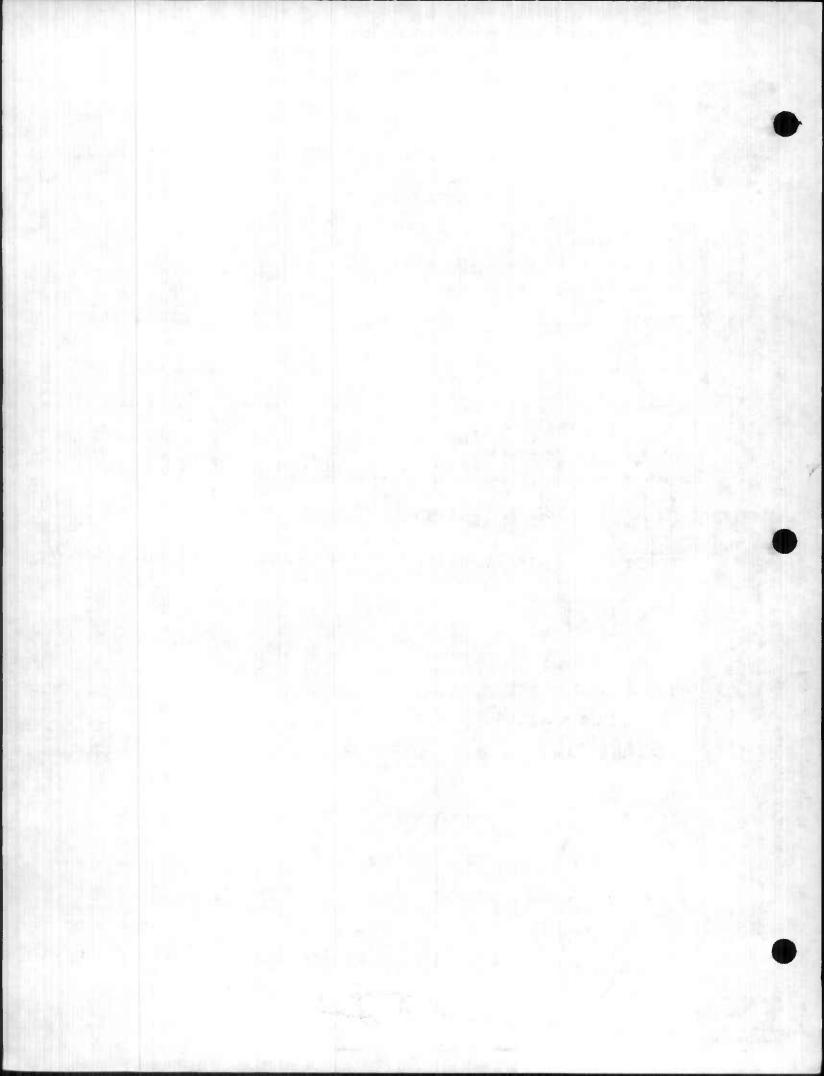
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the ceuse(s) and manner stated. 29c. License number 29b. Signature and title of pertifier

29d. Date signed (Month, Dey, Year)

30. Name and address of 23a) (Type, Print) M P

2000 DCT 18



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Yee NEZ 10:56 A.M Williams 12 00 10 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deet renesis Eldercare if Under 24 Hrs. 8. Dete of Birth Hours Min. Month, Pgy tomewood If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs, lest birthday) (Stete or Foreign Deys Months 244-34-635 Usuei Residence of Decedent 1 M 2 F South Yrs Carolina 10b. County 10c. City, Town or Location 10d. Inside City Limits Mary and 10XYes 2 No nor 10f. Zip Code 10g. Citizen of What Country? 215 12. Wes Decedent Ever In U.S. Armed Forces? 1 | Yes 2 | No If Yes, Give Year or Detes: 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Never Merried 2 Merried 1 Ves 2 No Specify. 3 Widowed 4 □ Divorced ASpecify *Hmerican* 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) 0 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 1941 rewe uirewe 19a. Informent's Neme/Relationship (Type, Phril) (daughter) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21133 S. Shir 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, crematory of other Dete 20c. Location - City or Town, State 1 Buriai 2 ☐ Cremetion 3 ☐ Removel from State 120/2000 Kida 4 ☐ Donetion 5 ☐ Other (Specify) 410 21. Signature of Funeral Service Lices 22. Name end Address of Fecility Rus Funeral Hom ve Balto Md. 21216 21216 W. North Ave Private the greese, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, or heart for ure. List only one cause on each line. Approximete Intervei Between Onset end Deeth tmmedlete Ceuse (Finel diseese or condition resulting in death) moran Minutes Corowar Due to (or es a consequenca of): Due to (or es e consequence of): 23b. Dfd tobacco use contributs to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Atrial 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 DNo 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

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page 2 should

funeral director,

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After

24 hours efter death.

Funeral Director: A

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Hospital

To

Completed by

Be

Medical Certification: To

physician

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, the Modes Experienment to make the inclined any injury or other traumatic avent, the Modes Experience may be inclined as

Baltimore, Maryland 21215-0020

Examiner Sequentielly IIsI conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Physician/Medicai

Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical exeminer? 26. Piece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

28e. Dete of tnjury (Month, Dey Year) 27. Manner of Deeth 5 Pending Investigetion 1 Naturei 2 Accident

Could not be determined

28b. Time of 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 29b. Signature and title of cardile

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pieca, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and pieca, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Yeer)

12,2000

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 115E,

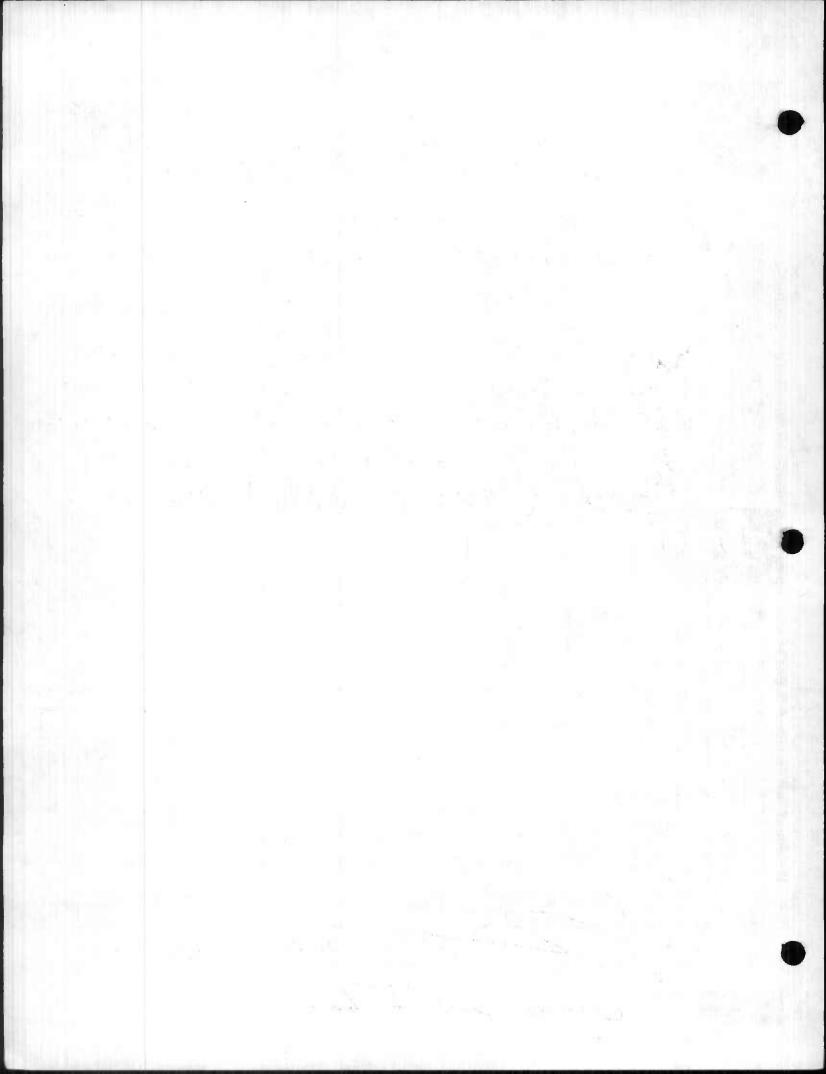
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32. Registrar's Signeture

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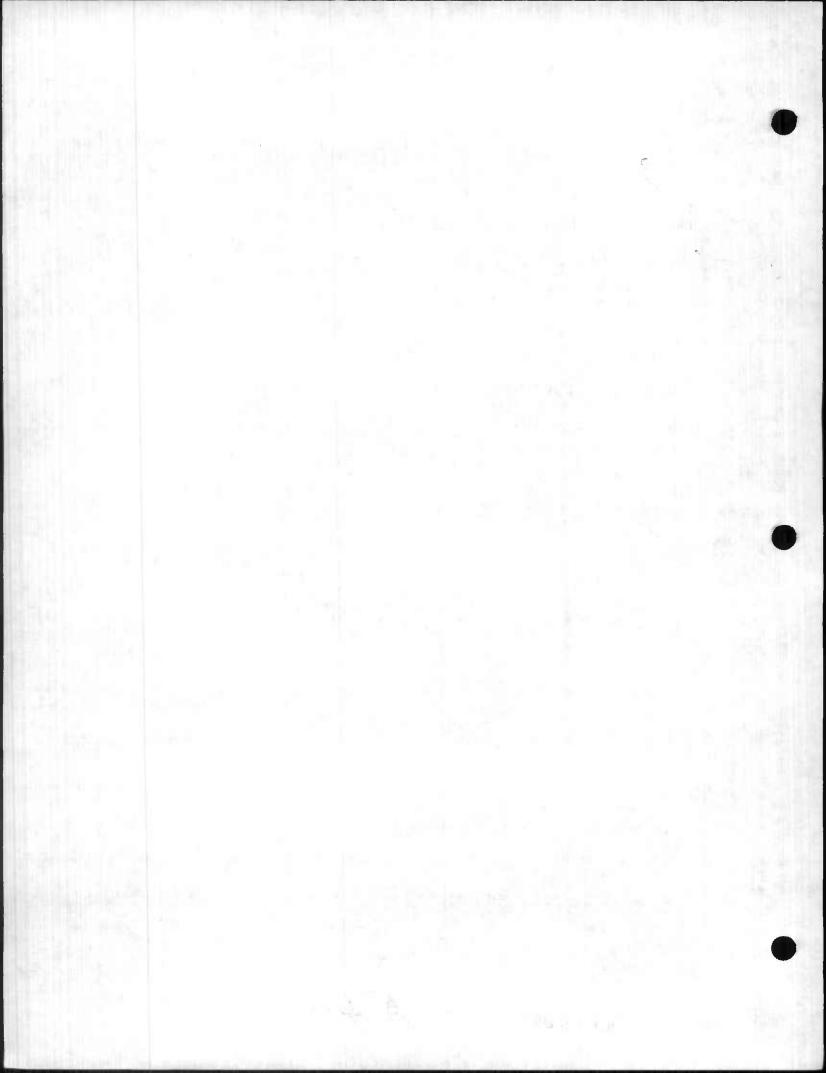
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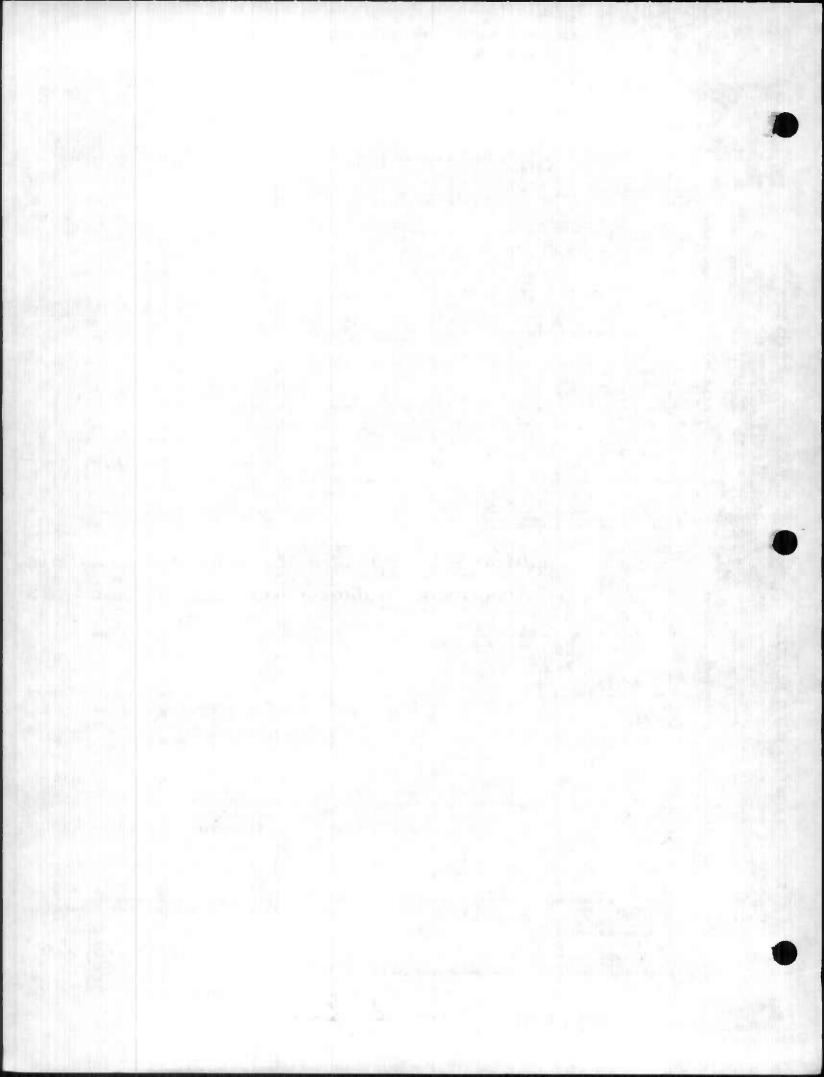
State of Maryland / Department of Health and Mental Hygiene

				te of Death	Reg.	UU	32915
Physician /Medical	1. Decedent's Nama (First, Middla, Las	een Wl	iite		2. Date of Death Month October	Day Year (2000)	3. Time of Death 5:30 PM
Examiner  Funeral Director	CC0271-812	and town/W	In Chest last birthday) H Unc Yrs. Month	er Balti er 1 Year If Under 24 Hi		4c. County of Deal	hplace (State or Foreign unity)
the Maryland 28a-f show noutrad at	Usual Residence of Decedent  10a. State  10b. County	A 100. CI	ty, Town or Location	ore,			10d. Inside City Limits 1 No Yes 2 No
23a or	10e. Street and Number 1506 Press	ser Ct.		21217		Citizen of What Co	untry?
urs atter	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:		sedent of Hispanic Origin? (pecify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, atc.)	14. Race - Ama Black, White Specify:	
and 21215-0020 be filed within 72 hours after that Hygiene. d other than 'natural', or ha event, the Mexical Examina event, the Mexical Examina Be Completed by Fu	15. Decedent's Edi (Specify only highast grad Elementary/Secondery (0-12)	cation la completed)  College (1-4or 5+)	16a. Decedent's U. (Give kind of a iife. DO NOT	vork done during most of w		. Kind of Business/	Home
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≥ 55 5 5	Mrs.Florise  20a. Method of Disposition  1 Burlal 2 Cremation 3 Di	White 206.	Plece of Disposition (A	Mount	St. Bal.	Md.	21217
Baltimore, permit. Pages 1 er Constrainent of Hear important: if item? any injury or other page.	4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licent	IV	T. Call 22. Nama Josev	and Address of Facility	5 Funero	len Bu	irnie, Md
Physician /Medical Examiner	23a. Part / Enter the disease, or comp shock or heart failure. List only of immediate Cause (Final disease or condition	lications that caused the dealine cause on each line.	n. Do not enter the m	ode of dying, such as card	ac or respiratory arrest.	W. Ma	Approximate Interval Between Onset and Death
68760, ificate be associted as the burial-transit as the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Olsease or injury that initiated events resulting in death) Last	Due to (c. Due to/c.	or also consequence of the same consequence of the sam	al visis	dr.	Disean	10 yn.
P.O. Box (that the death certified by the attending deteched for use a Physician M.)	Part II. Other significant conditions co	d	sulting in the underlying	g cause givan in Pert I.	23b. Did tobe	. /	to the cause of death?
Records, elew requires that been sign pe 2 should be mpleted by					24a. Was an a performed	17	Were autopsy findings available prior to complation of causa of death?
reiclen: The scentificete director, pag	25. Was case referred to medical examiner?	Hospital:	A FROM A STATE OF THE STATE OF	0	eath (Check only one)		1 Yes 2 No
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Division of To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29e. Certifier 118 Certifing Phy	building, etc. (Speci sician: To the best of my knoner: On the basis of examine	ry) owledge, death occurre	ed at the time, date and ple	City or Town, S	fafe) e(s) and menner as	s stated.
To the E within 2. To the F complete	29b. Signature and little of certifier	and manner stated.		9c. License number		Date signed (Mont	
State	30. Name and address of person who co	ompleted cause of death (Itel	123a) (Type, Print)	1 5/6.	N. Rollin	3 Rd	Bu K ny



State of Maryland / Department of Health and Mental Hygiene 0 32976

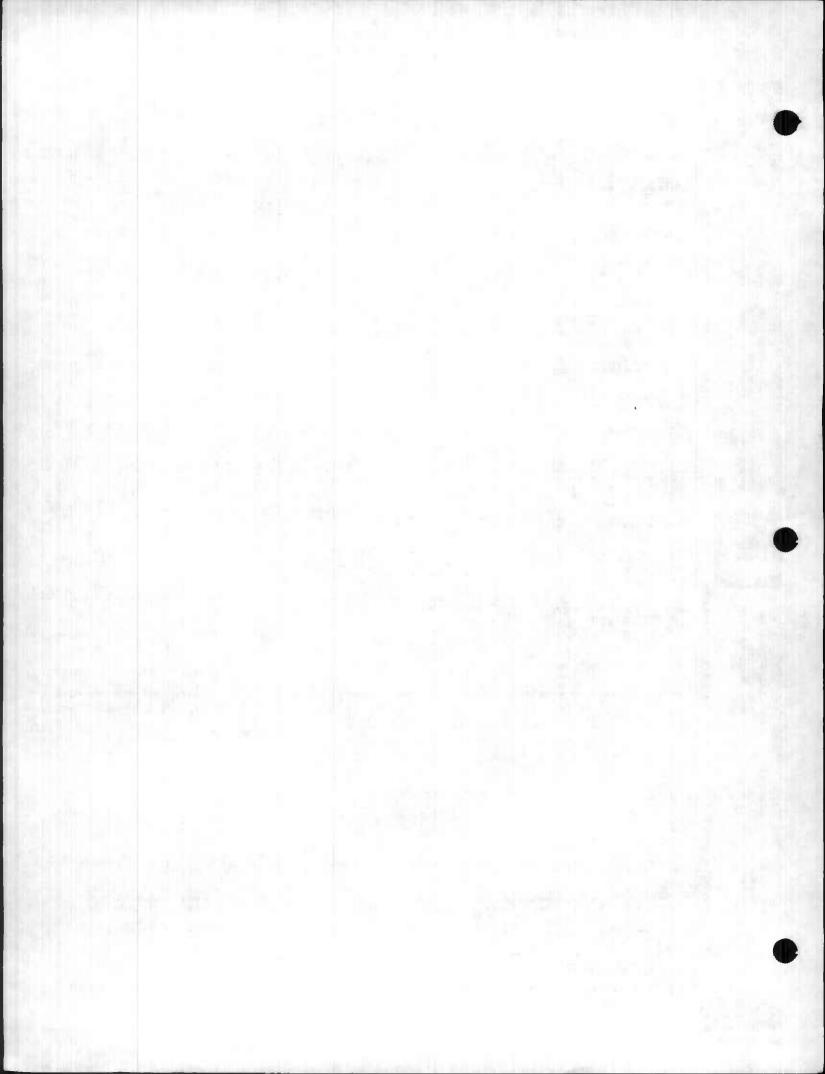
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		el Residence of Decede . State 10b. Co			10c.	City, Town or	Location					10d. Inside City Lim
mast be notified at mast be notified at eral Director				rundel			idena	Sur!				1 □ Yes 2 (1
or 21	10e	. Street and Number					10f. Zip Cod	е		10g. Citiz	en of What Co	untry?
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or heme 23 miner must Funeral	11.	Marital Status 1 ☐ Never Married 2	Married	12. Was Dec Armed Fe 1 X Yes	orces? 2 □ No 1	n U,S. 13 956-			gin? (Specify Yes or , Puerto Ricen, etc.)		4. Race - Ame Black, White	
D E		3 ☐ Widowed 4 ☐ Dive	orced	If Yes, Gi	NO	958	1□Yes 2	No Specify:			Specify: Whi	te
ted feet		15. Dec	edent's Ed	ducetion		16a. Dec	cedent's Usual Oc	cupation	of working	16b. Kin	nd of Business/	Industry
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di o	20a.	. Method of Disposition	tion 3 [	Removal from	State _		position (Name or rematory or other		Date		cation - City or	
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State of Maryland / Department of Health and Mental Hygiene

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					Ce	rtificat	e of	Death		F	leg. No.		06311
Dhysicis	_	1. Decedent's Name (First, Middle, La	st)	195						2. Dete of Dea Month		Year	3. Time of Death
Physicia /Medic	_	BETTY	MAE	WILL	141	115				Octo best	13,2	000	9:00 AM
Examine	_	4e Facility Name (If not institution, given	re street end number)				4	4b. City, To	wn, or Lo	cation of Death	4c. County	of Death	
		2 DELL	POURE				- 1	B14/2	410	PORE			
Funeral		5. Social Security Number 6. S	Sex 7. Ag	e (In yrs. las	t birthdey,	If Under	1 Year Devs		24 Hrs.	8. Date of Birth (Month, Day	Vest	9. Birth	place (State or Foreign
Director		227-58-4535 Usuel Residence of Decedent	10 M 20 F	53	Yrs.	Months	Deys	Hours	WIII.	1-14		C00	VA
No. No.		10a. State 10b. County	11.00-10.1	10c. City, 7	Fown or L	ocation			192				10d. Inside City Limits
E 12 44	ō	100		RA	1+1	Im.	OR	E					1 Yes 2 No
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Earl.	by Fur	11. Merital Stetus  1 Never Merried 2 Married  3 Wildowed 4 Divorced	12. Wes Decedent Armed Forces?  1  Yes 2 1  If Yes, Give Yeer or Detes:		13.		/	lispanic Ori en, Mexicar Specify:		ecify Yes or No- Rican, etc.)	Bia	ck, White	ican Indien, , etc.
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then the Ma	ошр	Elementary/Secondary (0-12)	College (1-4or 5	5+)		DO NOT U		,		744	GOVER	2111	MENT
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permit. Departe Importa any inja		21. Signeture of Funerel Service Lica	, /	nn	2	2. Name er	d Addre	ss of Fecili	Y HO	WELL	FUNZ	7214	L HOMME
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Physician	3	23a. Pert1. Enter the disease, or comshock, or heert feilure. List only	one ceuse on each li	the deeth.	Do not en	far the mod	le of dyir	ng, such as	cardiac	or respiratory an	rest,		Approximete Intervel Between Onset end Death
/Medical		Immediate Cause (Finel	1	ordi	20	1	- 1						1 -1001
Examiner		disease or condition resulting in deeth)	a	urona	1C	20	21/	vre				1	1 CIAY
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pe is	듣		b	eas:	+	Car	ce	5				1	7 years
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cian ouria		cause. Enter Underlying Cause (Disease or injury	c										
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he ad	180	Pert II. Other significant conditions of	contributing to death b	ut not resulti	ng In the u	underlying o	ause giv	en in Pert	1.	23b. Dld t	obacco una co	ontribute	to the cause of death?
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Physician: The this cartificate ral director, page	a a	25. Wes case referred to medical examiner?							of Deat	h (Check only o	na)		70 11 11 11 11
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ding Phys h. After this funeral d		27. Manner of Death  1 Natural 5 □ Pending	28a. Data of Inju (Month, De	v Year) 21	Bb. Tima o	of to	28c. Injur	y at		28d. Describe h	low injury occu	rred	
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l or Attending after death. Director: After I in by the fune	Certification:	3 Sulcide 6 Could not be datarmined	288. Place of inj	ury - At home	e, ferm, st	treet, fector	y, office					ber or Ru	rel Route Number,
व व व व व	e l	4 - Nomicios	building, et	c. (Specify)						City or Tow	n, State)		
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11/1	1	30. Name and address of person who	complated cause of d	laeth (Itam 2	3a) (Type	, Print)		-0	7	,		,	, 2000
Dul	11	1650 Orleans	St. C.	RB.	Kao.	hmor	e 1	Mani	lano	1 212	231		
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				/		100	- Kill	Chy 10 1	1				



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** SIDNEY OCTOBER 15, ZERWITZ 2000 1:05 PM /Medical 4b. City, Town, or Location of Deeth 4a Facility Nama (If not institution, giva street end number) 4c. County of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Under 1 Yaar 8. Data of Birth (Month, Day, Yeer) FEB. 21, 1911 If Under 24 Hrs. 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Months Days 10XM 2□ F 89 Director 213-10-7384 Usual Rasidence of Decedant 10a State 10c. City, Town or Location 10d. Insida City Limits 10b. County 28a-f show must be notified at 1 ☐ Yas 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? Herne 23a or 3403 WINTERSET COURT 21208 U.S.A. Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puarto Ricen, atc.) 14. Race - Amaricen Indian, Black, White, atc 72 hours after 1 Nevar Married 2 Married 1 ☐ Yas 2 ☑ No 21215-0020 8 1 ☐ Yas 2√ No Specify: þ Specify. WHITE 3X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa, DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Educetion (Specify only highast grada completed) filed within Elementery/Secondary (0-12) College (1-4or 5+) PHARMACIST PHARMACY Maryland 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Sumame) Be should be LOUIS ZERWITZ ANNA PARISER 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Steta, Zip Coda) WARREN ZERWITZ / SON 3403 WINTERSET COURT - BALTIMORE, MD 21208 if them 27 Baltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata Pages 7 1 Burial 2 ☐ Cremation 3 ☐ Ramovel from Steta ò 4 ☐ Donation 5 ☐ Othar (Specify) (ANSHE EMUNAH) AITZ CHAIM 10/17/00 BALTIMORE, MD 22. Nama end Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 If at caused the death. Do not entar tha mode of dying, such es cardiac or respiratory arrast, Interval Between Onsat and Death **Physician** Immediata Causa (Final diseese or condition rasulting in death) /Medical Examiner Due to (or as a consequance of) Physician/Medical Examiner TE usa as the bunal-transit The law requires that the death certificate be executed Sequantially list conditions, if eny, leeding to immadiata ceusa. Entar Undarlying Cause (Disaase or injury Box 68760 that initiated evants rasulting in daath) Last Due to (or as a consequence of) P.O. 23b. Did tobacco use contribute to the causa of death? Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown of Vital Records. Be Completed by 24b. Ware eutopsy findings evailable prior to completion of ceuse of death? 24a. Was an autopsy paga 2 should this cartificata has 1 Yas 2 No 1 Yas 2 No at or Attending Physician: T s after death. I Director: After this carificat of in by the funeral director, p 25. Was cesa rafarred to medicel 26. Place of Daath (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☑ Nursing Home 5☐ Rasidance 6☐ Othar (Specify) 1 Yas 2 No Certification: To 28c. Injury et Work? 27. Mannar of Deeth 28b. Time of 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Panding 1 Yas invastigation 6 Could not be determined 3 Suicida 28f. Location (Straet and Number or Rural Routa Number, City or Town, Steta) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) illed in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, deeth occurred et the time, deta end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) 29a. Certifier Madical end menner steted. To the 29b. Signetura and titla of certifian 29c. Licansa number 29d. Date signed (Month, Day, Year) a and eddrass of person who complated ceusa of daath-(Item 23a) (Type, Print) 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

Registrar

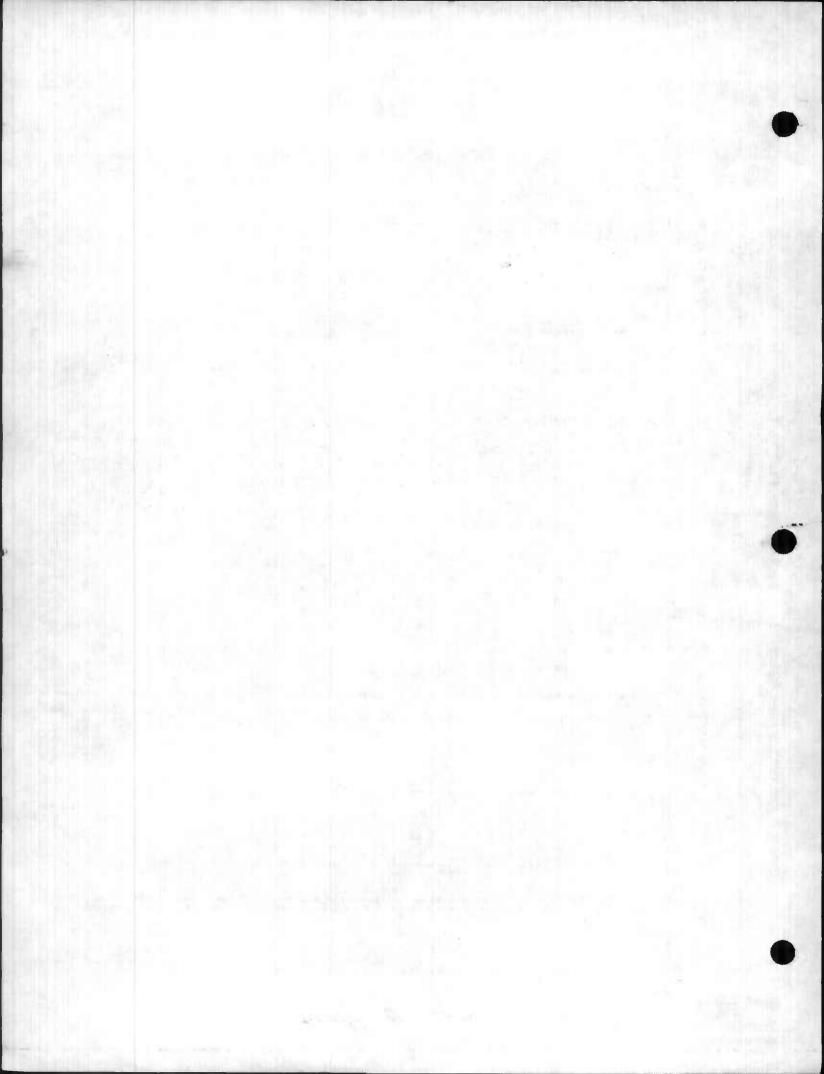
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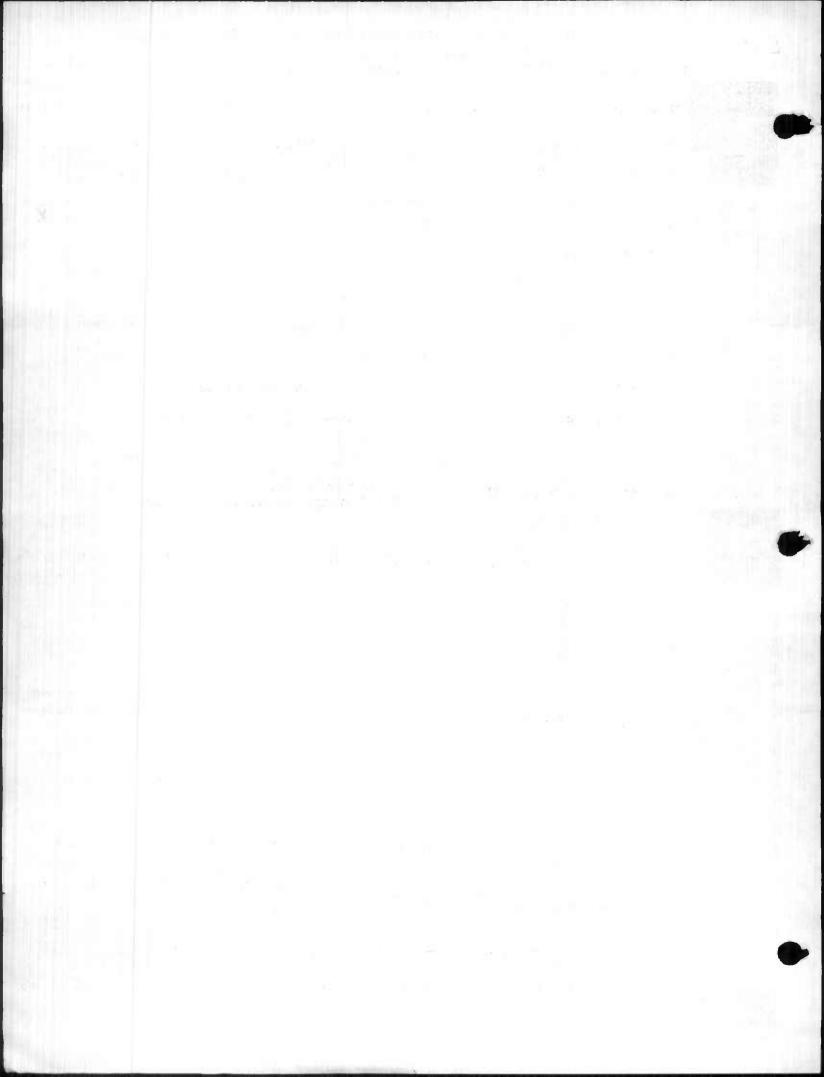
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			Cer	tificate of	Death	Reg	No.	32979
Physician	1. Decedent's Nama (First, Middle, Las	st)	71	n an = 0		2. Data of Death Month	Day	Year 30.44
/Medical	MARGARET		Cin	MERI		octobee	11	2000 6 M
Examiner	4a Facility Name (If not institution, give		- CENT	70	4b. City, Town, or Loca	ation of Death	Ac. County of	
	Crimaci		CENT	If Under 1 Yea	r   If Under 24 Hrs.   r	Data of Bish	1770	
Funeral Director	219-30-2691	ex 7. Age (In yrs. 89	Yrs.	Months Days	Moure Min	NOV , I	910	9. Birthplace (State or Foreign Country) Germany
P	Usuet Residence of Decedent  10a. State 10b. County	10c, Ci	ity, Town or Lo	cation				10d. Inside City Limits
or 28s-f sho be notified at Director	Maryland Anne Ar		altimor					1 ☐ Yas 2 🗓 No
	196 West Meadow	Rd.,		10f. Zip Code	21225	10g	. Citizen of W USA	hat Country?
215-0020 nn 72 hours after death vine 72 hours after death vine 124 Medical Examiner mast spleted by Funeral	11. Merital Stafus 1 □ Nevar Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Evar in L Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates:		Vas Decedent of Yes, specify Cu  ☐ Yes 2 No	Hispanic Origin? (Spec ban, Mexican, Puerto R o Specify:	ify Yes or No- ican, etc.)		White
5-0 72 h 72 h Marku Micel Micel Micel	15. Decedent's Ed (Specify only highest gra-	ucation de completed)	16a. Deced (Give	ent's Usual Occu	upation e during most of working ed)	16	b. Kind of Bu	siness/Industry
1 2121 led within tygiene. her then nt, the Me	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker	ed)		House	nui fo
Co Part	12 17. Fathar's Name (First, Middle, Last)	1	HOIII	ellaker	18. Mother's Nama	(First Middle Ma		
and the state of t	Sebastian	Schoder			Rose	(Unknow		•)
To To	19a. Informant's Name/Relationship (7		19h Mailin	n Address (Stree	et and Number or Rural			State Zin Code)
Magaga Ma	Joyce Orwig-Grand			-	Ct., Abingd			21009
Te, Hear John	20a. Method of Disposition	20b.	Placa of Dispos	sition (Neme of		-		City or Town, State
attimore mit. Pages 1- partment of He portant: If Nor y Injury or oth	1 Donation 5 Other (Specify	Mo	st Holy		er Cem. 10/	17/00 Ba	altimor	re, Maryland
Ball Department of the part of	21. Signature of Fuperal Segrice Licen	‱ Kevin E Eck ———	Mo		olyniak Fun			A. 21225-1856
SERVICE .	23a. Part1. Enfer the disease, or comp shock, or heart failure. List only	olications that caused the dea	th. Do not ente	er the mode of dy	ring, such as cardiac or	respiratory arres	l,	Approximate Interval Between
Physician	onough thouse tallotto. Electionly t		5					Onset and Death
/Medical	Immediate Cause (Final disease or condition	Sep	sis					Weeks
Examiner	resulting in death)	Due to (	or as a conseq	uence of):	n			0 1 10
8 # 6		Leg	VXCe	10/	gangrene			Thouth
n and isl-transit Examiner	Sequentially list conditions, if any, leading to immediate	2 Suntat	or as a conse	uence of):	0 5			
S8760 licate be e physician a the but at the but	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· ferry	renal	Vas	cular )	1 seas		years
5 0 4 4	resulting in death) Last	Due lo (d	or as a conseq	uence of):				/
at the death cer d by the attendin stuched for use Physician/N	Part II. Other significant conditions or		sulting in the ur	ndedving cause o	olven in Part I	23b. Did tobe	acco una con	stribute to the cause of death?
P.O. Part the of the	Caranary	Antom I	Dispas	6		1  Yes	2□ No	3 □ Probably 4 2 Unknown
by bed	_ ( 0 00 , 00 ) .	1100	7.3(-04					
The law requir page 2 should Completed						24a. Was an performe	autopsy od?	24b. Were autopsy findings available prior to completion of cause of death?
The law required to page 2 should						1 ☐ Yes	2 25No	1 ☐ Yes 2 X No
Altal Security	25. Was case referred to medical				26. Place of Death			
To digital of	examiner? 1  Yes 2 No  27. Manner of Death 1  Natural 5  Pending	Hospital: 1 Inpatient 2 Inpatient 28a. Date of Injury (Month, Dey Year)	ER/Outpatien 28b. Time of Injury	28c. Inj	ther: 4 Nursing Hom		ca 6 🗷 Othe	The state of the s
Division of the or Attending P as a Director: Alea: Bed in by the turner Certification:	2 Accident investigation 3 Suicide 6 Could not be determined		nome, ferm, str ify)			81. Location (Stre City or Town,		er or Rural Route Number,
Hospi 24 hour Funer Hosy III	29a. Certifier (Check only 2 Medical Exam	yeiclan: To the best of my known. On the basis of examination and mannar stated.	owledge, death ation and/or inv	occurred at the restigation, in my	time, date and placa, er opinion, death occurred	nd due to the cau d at the time, date	se(s) and ma e and placa, a	nner as stated. and due to the cause(s)
Me And The	29b. Signature and title of contiller	20)	<b>\</b>	29c. Licer	nse number	290	l. Date signed	(Month, Day, Year)
10	1 reffer	un M	)	17	24055		10/15	100
2/0	30. Name and address of person who o	completed cause of death (Ite	m 23a) (Type,	Print)	s. PARK	ISCE N	1/	21234
State	31. Data filed (Month, Dey, Year)	32. Registuar's Sign	nature	100	21 / 1110	1.1	, , ,	210/
Registrar		2000 Dener	w for	Apo	rels			



Examiner    Secretary Name   Food methodoc give steemed or pushed   Compared   Compared	nysician		1. Decedant's Nam		A						2. Dete of D Month	D	еу	Yeer	3. Time of Deat
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To Sales   100. Colary   100. Colary   100. Colary   100. Colary   100. Colar   100	_		241-64-3179	9	Sax 7. 1 △ M 2 ☐ F	Age (In yrs. 58					n. 8. Date of B	irth	r)	9. Birthp	lace (State or Fore
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Elementerly Secondary (0-12)  12 th  17. Fathar's Name (First, Middin, Last)  Codege (1-4or 5+)  Auto Worker  18. Momen's Name (First, Middin, Median Summan)  Louise Barksdale Wadden Summan)  20. Method of Disposition  Jean Atticins – Wife  20a. Method of Disposition  Jean Atticins – Wife  20b. Method of Disposition  Jean Atticins – Wife  Atticins – Wife  Jean Att	Examiner m	2	1 Nevar Marr		Armed Force 14 Yas 2[ If Yes, Give	s? ⊒ No	1				(Specify Yes or Nerto Rican, atc.)	0-	Blad	ck, White,	etc.
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23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Cheek and Death Interval Between Cheek Interval Betw	o Be (	3			t)									na)	
230. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between cheek and beeth medical sease or condition.  The production of the p														State, Zip	Code)
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23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between check or heart failure. List only one cause on each line.  Approximate a shock, or heart failure. List only one cause on each line.  Approximate a shock, or heart failure. List only one cause on each line.  Approximate a shock, or heart failure. List only one cause on each line.  Approximate a shock, or heart failure. List only one cause on each line.  Approximate a shock, or heart failure. List only one cause on each line.  Approximate a shock, or heart failure. List only one cause on each line.  Approximate a shock, or heart failure. List only one cause on each line.  Approximate a shock, or heart failure. List only one cause on each line.  Approximate a shock, or heart failure. List only one cause on each line.  Approximate a shock, or heart failure. List only one cause on each line.  Due to (or as a consequence of):  Approximate a shock or heart failure. List only one cause or heart failure. List only one cause or heart failure. List only one cause or cause of deeth?  Due to (or as a consequence of):  Approximate a shock or heart failure. List only one cause or heart failure. List only one cause or heart failure. List only one cause or cause of deeth?  1   Yee 2   No 3   Probably 4   Definitions or heart failure. List only one cause or heart failure. List only one cause or heart failure. List one cause or cardial or respiratory arrest.  Approximate a shock or respiratory arre	once.		21. Signeture of Fu	uneral Service Lice	nsea		22 No	. Name en utter	nd Addre		inc.	1		1113,	M.D.
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25. Wes case referred to medical exeminer?  26. Piece of Deeth (Check only one)  27. Manner of Death  28. Piece of Deeth (Check only one)  280. Deeth Injury of Deeth one)  281. Location (Street and Number or Rural Route Number, Chy or Town, State)  4122 Buckingham Road, Balto., MD  292. License number  292. License number  293. Deeth Signed (Month, Dey, Year)	by Physician/Medical Examiner	F	Immediate Cause disease or conditic resulting in death)  Sequentially list co if eny, leeding to in cause. Enter Unda Cause (Disease or that initiated events resulting in death)	(Finel on ditions, and die darlying Injury St. Lest	b. c. d. contributing to death	Due to (co	or es e consequence as a consequence as	juenca of): uenca of): uenca of):	of dylr	ng, such as cardi	23b. Dic	tobacc	o use co 2 No	ntributa to	Interval Between Onset and Deeth ONE WILLIAM ONE WILLI
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29a. Certifier (Check or one)  29b. Education of the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.  29a. Certifier (Check or one)  29b. Education of the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.  29b. Education of the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.  29c. License number  29d. Deta signed (Month, Dey, Year)	To Be Completed by Physician/Medical Examiner		Immediate Cause disease or condition resulting in death)  Sequentially list confirmed in the cause. Enter Unde Cause (Disease or that initiated events resulting in death).  Pert II. Other algniff  Pert III. Other signiff  25. Wes case refer exeminer?  1	onditions, nadiate atribing linjury stept	bdd	Due to (co	or es e consequer as a consequer as	L C Juenca of):  uenca of):  uenca of):  uenca of):	de of dylr	yen in Pert I.  28. Plece of D  ner: 4□ Nursing	23b. Dic 1 24e. We perint 1 0 eeth (Check only)	I tobacc I Yes s en automed? Yes one) Idenca	o use con 2 No No opsy	antributa to  3 Prob  24b. We ave corror of control of the control	Intervel Between Onset and Deeth Onset and Dee
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	uneral director, page 2 should be datached for use as the bunal-transit and buna-transit and buna-tran	2	Immediate Cause disease or conditic resulting in death)  Sequentially list co if eny, leeding to in cause. Enter Unda Cause (Disease or that initiated events resulting in death)  Pert II. Other significance of the cause of the cause (Disease or that initiated events resulting in death)  25. Wes case reference of the cause of the	red to medical No h 5 Pending investigatic 6 Could not to determined	b.  c.  d.  contributing to death  Ry  Hospitel: 1 Inpa  28e. Dete of tr  (Month, I  Unknown  28e. Pleca of building,  hysician: To the besimmer: On the basis	Due to (co	or es e consequer es	uenca of):  uenca of):  uenca of):  uenca of):  uenca of):  uenca of):  andarlying c  t 3 □ DC  andarlying c  cocurred c	DA Other Words, in my o	zen in Pert I.  28. Plece of D  ier: 4 Nursing yet k? Yes 2 No	23b. Did 24e. We period  10 24e. We period 25d. Describe 28d. Describe 28f. Location 4122 But	tobacc Yes  s en automed?  Yes  one) Idenca how Injunof (Street e wn, State king) cause(i, date er	o use con 2 No No opsy  6 Oth or correction of Number (e) ham Riss) and mand place,	antributa to  3 Prob  24b. We ave corror of corror (Specify red DSIVE Sper or Rura.  Oad, B. anner as st and due to	Intervel Between Onset and Deeth Deeth Deeth Onset And Deeth D



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend item#24a perPHYg788 10/19/2000 EW Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3. Time of Death Month Yaar **Physician** Marlene Ruth Barber 0752 octoben 2013 /Medical 4e. Fecility Neme (If not institution, give street end number) 4h City Town or Location of Deeth 4c. County of Death Examiner Union Memorial Hospital Baltimore City Baltimore City If Under 24 Hrs. 5. Social Sacurity Number If Undar 1 Yaar 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Hours 1□ M 2□ F 217 38 7499 Yrs. Director 60 Baltimore Co., Md. Usual Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Baltimore County 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 2121 Summit Avenue **Нете 23**а 21237 USA death Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No Wes Decedent of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Meritel Status traumatic event, the Madical Examiner Bleck, White, etc. mit. Peges 1 and 2 should be filed within 72 hours after partment of Health and Mental Hygiene. parant: If item 27 is marked other than "natural", or ite 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 If Yes, Give Yaar or Detes: 1 ☐ Yes 2 ☐ No Specify: Specify: b 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) WA Teaching Assistant Towson High School 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Joseph Leo Mills Sr Evelyn Geraldine Socks 19e. informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Earl E Barber (Husband) 2121 Summit Avenue Baltimore, Maryland 21237 20b. Pleca of Disposition (Neme of cemetary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriai 2 ☐ Cremetion 3 ☐ Removel from State pemit. P.
Countmen.
Important: 1 Gardens of Faith Cem. October 16 2000 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Neme end Addrass of Facility Lassahn Funeral Home Inc 23a. Pert1. Enter the disaase, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart tellure. List only one cause on each line. Approximate Intervei Between Onset and Deeth **Physician** /Medical immediata Cause (Finel Infaction 2 days Myocardial diseese or condition resulting in death) Examiner Due to (or es e consequence ot): The lew requires that the deeth certificate be executed the burial-trensit Sequentielly list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest and Due to (or es e consequence of): Records, P.O. Box 68760, ettending physician for use es the buria Physician/Medical Due to (or es e consequence of): signed by the e Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yee 2 ☐ No 3 Probably à Completed 24b. Were eutopsy tindings avellable prior to 24e. Wes an eutopsy performed? peed completion of cause of death? page 2 s 1 XYas 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t Be 25. Wes case reterred to medical 28. Place of Deeth (Check only one)

10 Certification:

Hospitel: 1 Anpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28b. Time of

Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending invastigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the ceuse(s) and manner es steted.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the tima, dete end piece, end due to the cause(s) and menner steted. 29e. Certifier 29b. Signature and title of certifly

29c. License number 29d. Deta signed (Month, Dey, Year) 13 < 4865373 16/12/00

30. Name and address of person who complated cause of deeth (Item 23e) (Type, Print)

MIP. Unisa Memorial Hospidal (00 31. Dete tiled (Month, Dey, Year)

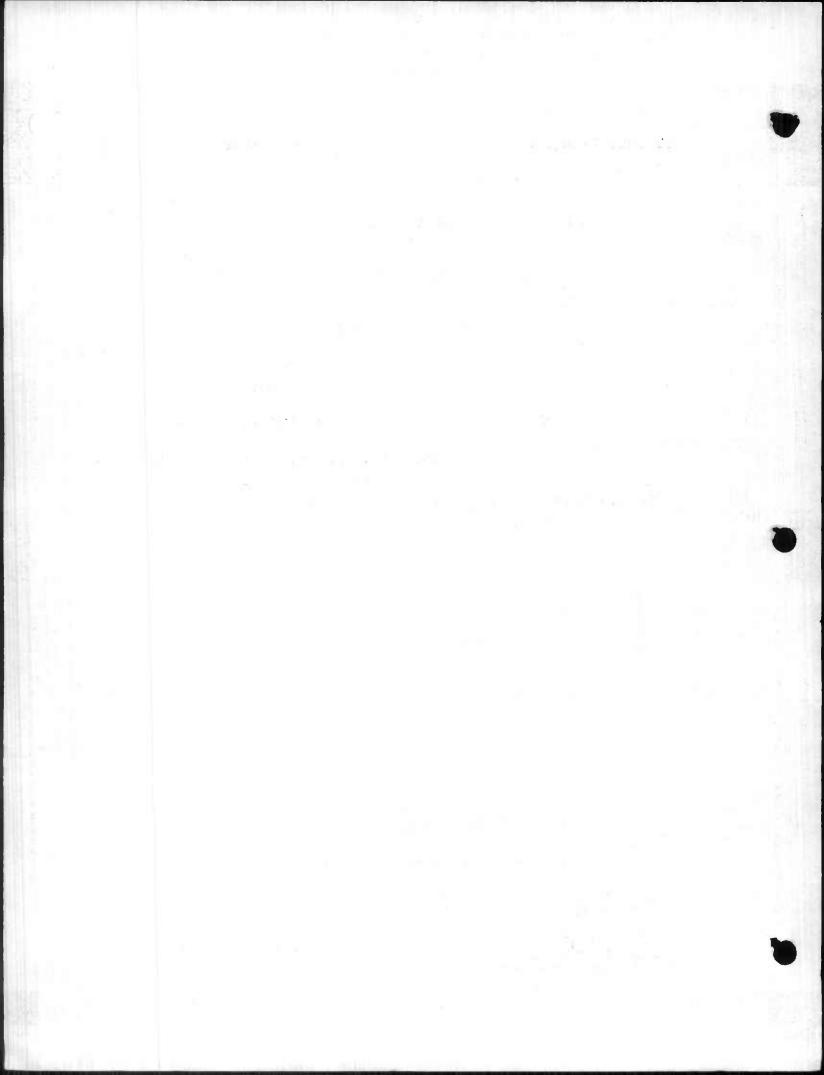
State Registrar

Medical

32. Registrer's Signatura

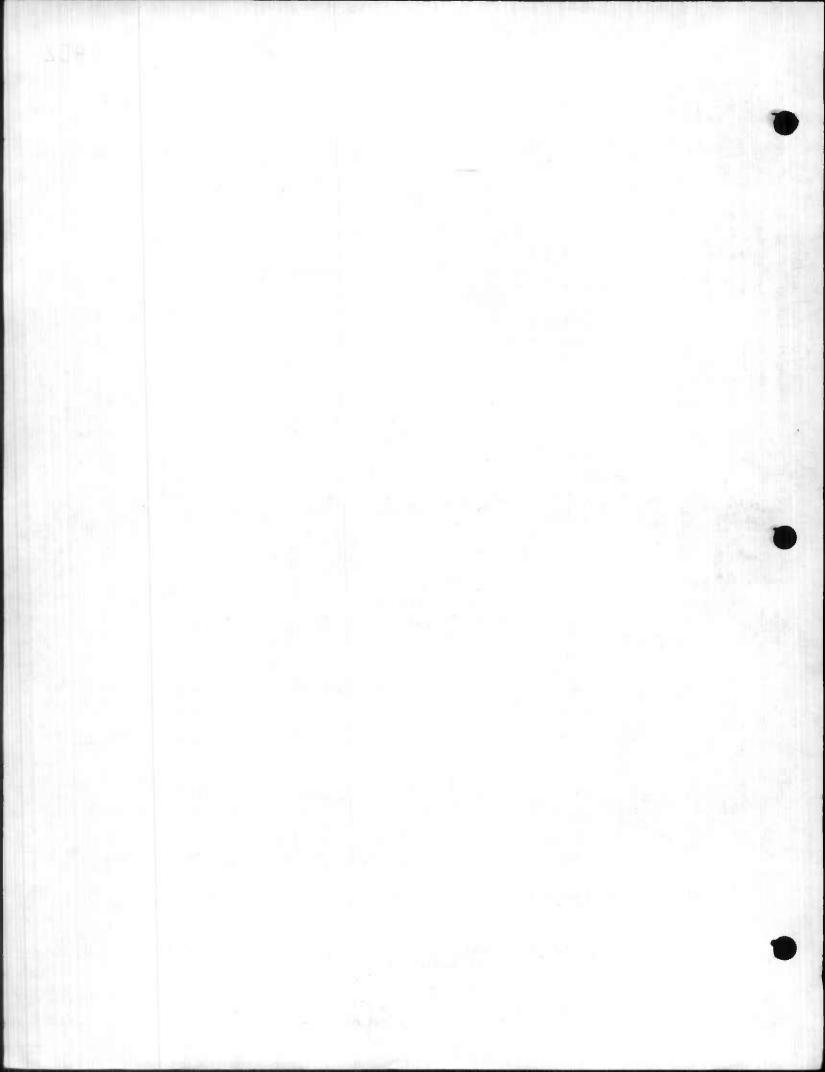
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Division of Vital



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Amend Ita	m#7 perFHG788 10/19/2000 EW Certificate of Death	Reg. No.
	1. Decedent's Name (First, Middle, Last)	2. Date of Death  Menth  Day  Year
Physicia /Medica	45 Foreign Marchinethalous plus street and austral d	Utober 01, 2000 2300
Examine	Maryland General Hospital Butimon	e City
Funeral Director	5. Social Security Number 6. Sex 1 Months 1 Mont	(Month, Day, Year) Jan 9, 1911  9. Birthplace (State or Foreign Country) unk
Maryland e-f show lifed at	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ₺ Yas 2 □ No
	10e. Street and Number 1213 Light Street 21201	10g. Citizen of What Country?
20 arter death or items 23 artifier mass	11. Marital Status Unk 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? Unk 1 Never Married 2 Married 13. Was Decedent of Hispanic Origin? (Spe If Yes, apecify Cuban, Mexican, Puerto	Rican, etc.) Black, White, etc.
thours thours	3 Widowed 4 Divorced Year or Dates:	1 10h Mind of Business Reductor
21215-0020 d within 72 hours at glans or than "netural", or the Medical Exam	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondary (0-12) unk  16a. Decedent's Usual Occupation (Give kind of work done during most of workii life. DO NOT use retired)	unk loo. Kind of Business/Industry unk
D all the	17. Father's Name (First, Middle, Last) unk 18. Mother's Name	(First, Middle, Maiden Sumame) unk
C - N -	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura	al Route Number, City or Town, State, Zip Code)
Baltimore, semil. Pages 1 a pearlment of Hea mportant: If Isam iny Injury or other interests.	20a. Method of Disposition  1 Burial 2 Cremetion 3 Remoyal from State 4 Donation 5 Other (Specify) In State	Date 20c. Location - City or Town, State
Balt Parity Pari	21 Sprature of European Spratter State Anatomy Boar Baltimore, MD 212	d 655 W. Baltimore Street
Physician	23a. Parti. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	or respiratory arrest, Approximate Interval Between Onset and Deeth
/Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)  a. Gastrointestinal bleed	
B	Due to (or as a consequence of):  Description of a consequence of the	
68760, filtere be executed physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that imitiated events rasulting in death) Last  Due to (or es a consequence of):  Due to (or es a consequence of):	irtery disease
. 0 00	d  Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contributs to the cause of death?
		1 Yes 2 No 3 Probably 4 Onknown
Records,		24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?
The law		1 Yes 2 No 1 Yes 2 No
of Vital I	Hospital: Hospital: 2 FER totalist 2 DA Other: 4 Atomics Hospital	n (Check only one) me 5 ☐ Residence 6 ☐ Other (Specify)
After fune	Teamperent 20 craobation 30 box 40 months not	28d. Describe how injury occurred
Division  or Attending s after death. I Director: After d in by the fune	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 4 Homicide 28e. Dete of Injury 28b. Time of Injury Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
n 24 hour n 24 hour n 24 hour n Funer pletely fill	29a. Certifler (Check only one)  1 Certiflying Physician: To the best of my knowledge, death occurred at the time, date and place, a construction of the control of the con	and due to the cause(s) and manner as stated. ed at the time, date end place, and due to the cause(s)
To the Tour company	29b. Signature and title of confidence of the second secon	29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (flem 23a) (Type, Print)  AND ACIANS MD, CO MAN AND General	Hospital
State Registra	OCT 1 9 2000 Server & Sonature	

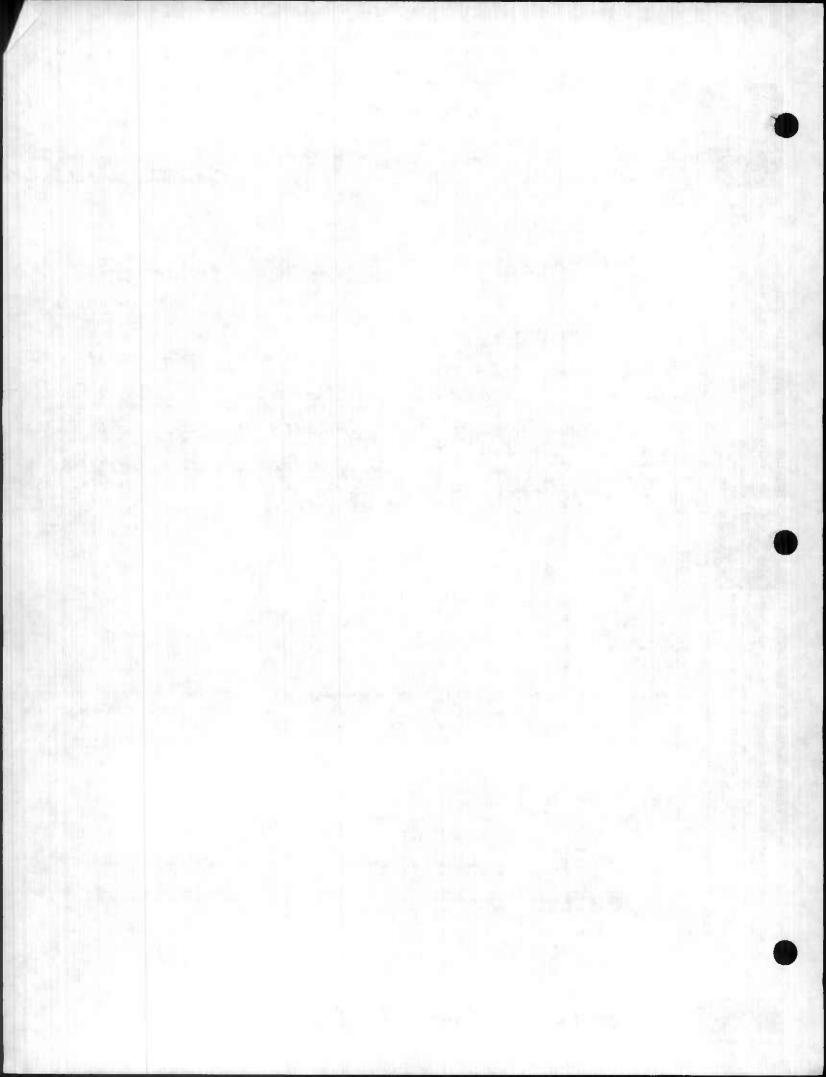


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State of Maryland / Department of Health and Mental Hygiene 3 2 9 8 3

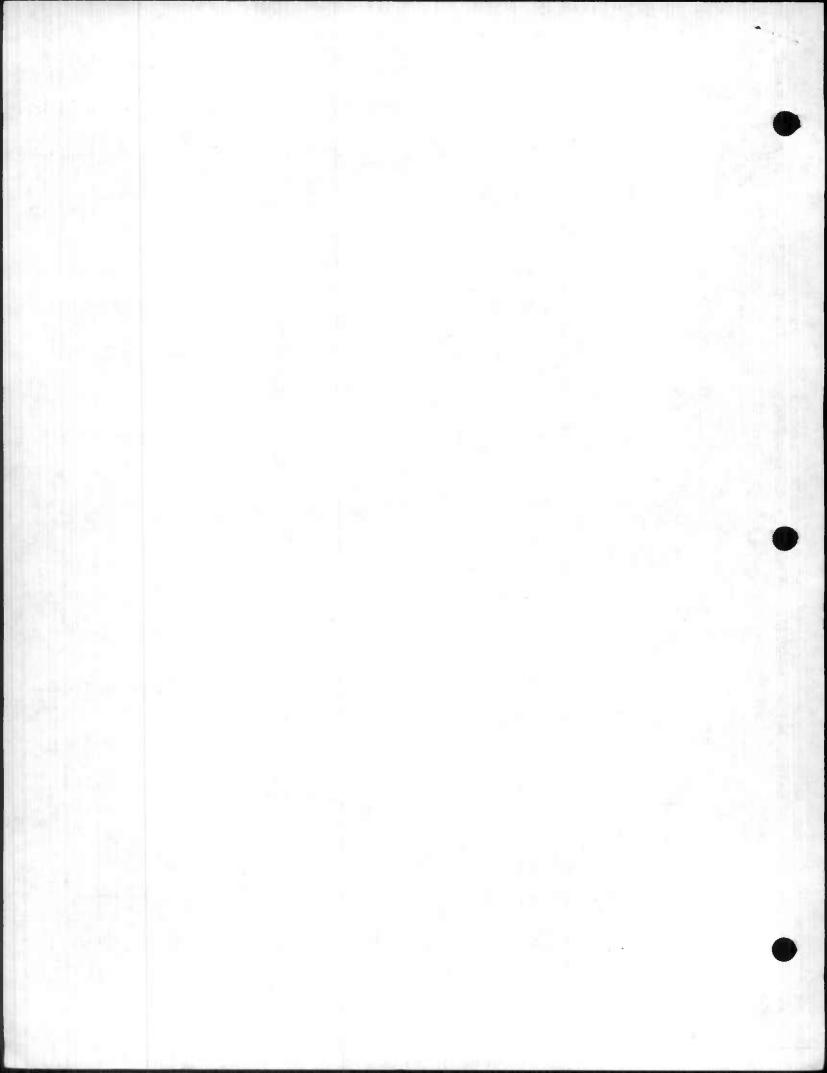
Certificate of Death

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aminer	4a Fa	cility Name (If no	t institution, gi	ive street and nu	m <i>ber)</i>			4b	. City, Town, or L	ocation of Deat	th 4c. County	of Death	
	6	155	Tou	NE B	ROOK	DR.1	APT F	-	BALT	THORE		NI	A
eral	5. Soc	iel Security Num	ber 6.	Sex	7. Age (In yrs.		If Under	1 Year Deys	If Under 24 Hrs. Hours Min.	8. Date of Bi		9. Birthp	plece (Stete or For
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be notifie Directo	10e. S	treet and Numbe	ır				10f. Zip				10g Citizen of W	hat Cour	ntry?
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State of Manyland / Department of Health and Mental Hydiene

sician	1. Decedent's Name (First, Middle,	Last)		rtificate of	2000.7	2. Date of Dea			ime of Death
edical	LULI			BARNES	4b. City, Town, or Lo	Octobe	r 7,2		2:19P
miner ral	213-36-6701	PKINS HOSP	yrs. last birthday)	If Under 1 Year Months Days	BAUTIMOR		y	9. Birthplace (Country)	State or Foreig
	Usual Rasidence of Decedent  10a. Stata 10b. County	10c	City, Town or Lo	ocation				10d. In:	slde City Limits
to	mo N	A B	ALTIMOR	E				16	ZYes 2 N
Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?	
	1303 ASHLAND	AVENUE		212	05			LSA	
by Funeral	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forcas?  1  Yes 2 No if Yes, Give Year or Dates:	1	Wes Decedent of It Yas, specify Cub	Hispanic Origin? (Spean, Mexican, Puerto Specify:	ecity Yes of No- Rican, etc.)		- American Inc k, White, etc.	nan,
	15. Decedent's	s Education	16a. Deced	dent's Usual Occu	pation	ina	16b. Kind of Bu		
Completed	(Specify only highest Elementery/Secondary (0-12)	College (1-4or 5+)			during most of work	ing .			====
	8 TH GRADE  17. Father's Name (First, Middle, Li	NA	MACH	INE OF	ERATOR 18. Mother's Name	/First Middle	LUCAS Suman	BROTH	FKS
o Be	JAMES MAVO	noi/			MARIE	BEEC!			
T	19e. Informant's Name/Relationshi	ip (Type, Print)	19b. Mallin	ng Address (Stree	tand Number or Run			State, Zip Code	)
	WILLIE BARNES		1303		UD AVE.			21205	
	20a. Method of Disposition	20	b. Place of Dispo		,	Date	20c. Location -	City or Town, S	tate
	1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donetion 5 ☐ Other (Spe	ecify)			METERY !	0.14.06	BALTO. 1	no	
850	21. Signature of Funeral Service Li								
8	Vaugh-	A-	151	51 BAUC	. NATE P	IKE. BL	TUTO. ME	2122	9
30	23a. Part 1. Enter the disease, or c shock, or heart failure. List or	omplications that caused the only one cause on each line.	death. Do not ent	ter the mode of dy	ng, such as cardiac	or respiratory a	rest,	Inter	oximate val Between et and Death
	Immediate Cause (Final								
Н	disease or condition resulting in death)		PSIS	4240 5 6				1 3	DAYS
اةٍ ا			to (or as a consec		ARCTIOI	V		2	DAYS
Examiner	Sequentially list conditions,	b	to (or as a conseq		.,, 0 , , 0 ,	<u> </u>		3	01112
	Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or injury	V	ASCULA	R DIS	EASE			1	YEAR
8	that suriated exemp	Due t	o (or as a conseq	quance of):					
Medical	resulting in death) Last	d							
sician/Medi	resulting in death) Last  Part II. Other significant condition	d	resulting in the u	inderlying cause g	iven in Part I.	23b. Did	obacco use con	tribute to the	cause of dea
Physician/Me	Part II. Other significant condition	d					tobacco use con Yes 2□ No	atribute to the	
by Physician/Me	Part II. Other significant condition					1 🗆 24a. Was		3 Probably  24b. Were au available	4 Unknow
by Physician/Me	Part II. Other significant condition					1 🗆 24a. Was	Yes 2□ No an autopsy rmed?	24b. Were at available complet	4 Unknown
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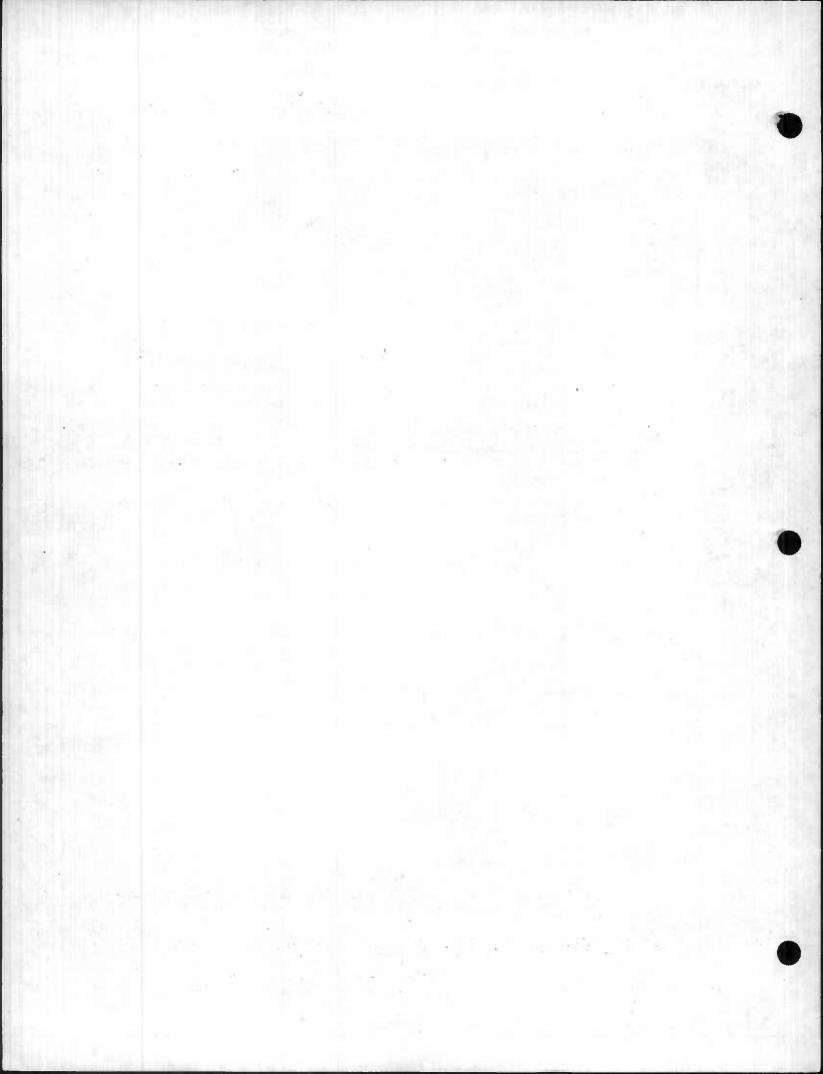


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18.4 . 12	1. December s Neme (First, Middle,	, Last)		BI	1/4 2	Date of Death Month	Day 4 200	- 11.17
/Medical Examiner	4a Facility Name (If poplinstitution,	SBAYVERWI	MEDICAL (In yrs. last birthda	EXTER WI If Under 1 Year		PORE	4c. County of De	eath
Funeral Director	193-16-7271 Usuel Residence of Decedent	1\\ M 2□ F 75		Months Deys	Hours Min.	Dete of Birth (Month, Day, Y Ct. 26,	1924 P	tirthplace (State or Fo Country) ENNSYLVANI
dist.	10a. Stete 10b. County		10c. City, Town or	Location				10d. Inside City L
or 28e-fr	Maryland	N/A		Baltimo	re			
				10f. Zip Code		100	. Citizen of What	
free med	5138 Wright Ave	2nue 12. Was Decedent E	ver In U.S. 13		205 Hispenic Origin? (Specif	v Yes or No-	U. S	A . merican Indian,
ar, or the		Armed Forces?  1 X Yes 2 No If Yes, Give Yeer or Detes:	0	If Yes, specify Cub 1 ☐ Yes 2 No	Hispenic Origin? (Speciforn, Mexican, Puerto Ric Specify:	án, etc.)	Specify:	hile, etc. White
ted less	15. Decedent's	's Education	16a. Dec	cedent's Usuel Occu	petion	16	b. Kind of Busines	ss/Industry
ed within 72 ho yglene. wer than "neture it, the Medical.	(Specify only highest Elementery/Secondery (0-12) 8th Grade	College (1-4or 5+	·)	Machinis	during most of working d) t		Electro	nics
E STEE	17. Father's Neme (First, Middle, L				18. Mother's Neme (I			
Merrico Merric					Elizabe			
T is m	19e. Informent's Neme/Reletionsh				t end Number or Rural F			
Hoan 2	Maxine L. Balko	(wege)	20b. Piece of Dis	b wrught in position (Name of remetory or other ple	Avenue, Bal		c. Location - City	
0 10 0	1 Buriel 2 □ Cremetion 4 □ Donetion 5 □ Other (Sp				lets. Cem. 10,	200		
infur.	21. Signature of Funerel Service L							ss, marge
ded years	23a. Part1. Enter the diseese, or canock, or heert failure. List of	Kelly		3331 Brei	ess of Fecility & Funeral H hms Lane, B	altimor	e, Maryl	and 21213
Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in deeth)	a HYPENTE	NSTVR T		BRAL HEA	nozkata	gr.	Onset and Dea
physician and s the buriel-transit	Cause (Disease or injury that initiated events resulting in death) Last	С	Due to (or as a cons					
0 0								
2 4								
by the attending tached for use as thysician/Me	Pert II. Other algnificant condition	ns contributing to death but	t not resulting in the	underlying cause g	iven in Pert I.	23b. Did tob		
es mat the bearing igned by the attending be detached for use as by Physician/Me	1 Michille St	ne contributing to death but	t not resulting in the	underlying cause gi	ven in Pert I.		2 10 No 3 0	b. Wera autopsy find evailable prior to completion of caus of death.
a taw requires that the beam certificate bas been signed by the attending be 2 should be detached for use as mpleted by Physician/Me	1 Michille St	ns contributing to death but	t not resulting in the	underlying cause gi	iven in Pert I.	1 ☐ Yes	eutopsy 24	b. Wera autopsy findi evailable prior to completion of caus
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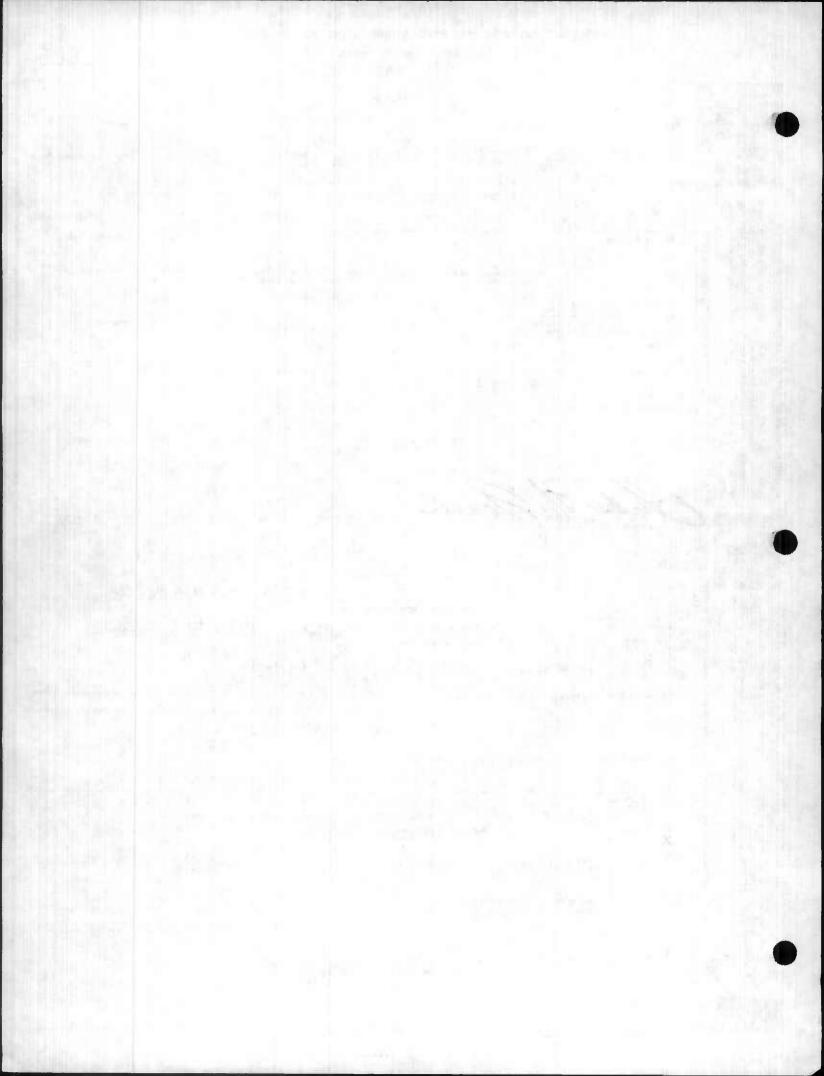
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acn	TERRY	NATHANIEL B  1. Decedent's Name (First, M.			Cer	tificate of	Death	2. Data of I	Reg. No.		3. Time of Death	
	Physician							Month				
	/Medical Examiner	TERRY N  4a Facility Name (If not institu	IATHANIEL rtion, giva street and n	BROOKS rumber)			4b. City, Town		or Location of Death 4c. County of Death			
135	Examine	Indiana in the second of the second	SPITAL				BALTIM	ORE				
F	uneral	5. Social Security Number	6. Sax	Trigo (Trigot Table Directory)		If Under 1 Yaar Months Days		Hrs. 8. Date of 8	Birth			
Director  punishing		220-96-7603	XXM 2□ F	20	Yrs.	Months	nours		5 1980		YLAND	
	*	Usual Residence of Decedent  10a. State 10b. Cou		10c City	Town or Loc	eation					10d. Inside City Limits	
	or ada			,,							1/2Yes 2□No	
2	or 25a-f a be notified Director	MARYLAND No. Street and Number	I/A	BALTIMOF 100.					10g. Citizen o	f What Cou	ntrv?	
21215-0020 3 within 72 hours after death with the Marylas plans. Then "natural", or fears 23s or 25s-f show the Medical Examiner must be notified at	Se of	2119 N FULTON AVENUE 2121					217					
	ioer must Funeral	11. Marital Status	12. Was De	cedent Ever in U,S	. 13. W			? (Specify Yes or I		aca - Aman		
		VONever Married 2 N 3 Widowed 4 Divor	farried 1 ☐ Yes	1 Yes 2 No		Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes ♣CXNo Specify:			Black, White, etc.  Specify: BLACK			
	lest bet	15. Decedent's Education 16a. Decedent's Usuat Occupe (Specify only highest grade completed) (Give kind of work done of					pation	f working	16b. Kind of	16b. Kind of Business/Industry		
	t, the Medical	Elementary/Secondary (0-12) College (1-4or 5+)					Working					
12 N		11th grade					40 Mathada	Name (First Mide		RETAIL		
Maryland d 2 should be fill th and Mental H 7 is marked out traumatic even	B 20	17. Father's Name (First, Midd						Name (First, Middle, Maiden Surname)				
	To	CLARENCE C F			10h Mailin	Addrage /Strag		ICE M TA		m State Zi	a Code)	
	17 ts	Clarence C.		her				Baltimo				
6 - 3	offse of the	20a. Method of Disposition	BIOOKS/ Fac	20b. Pia	ce of Dispos	ition (Name of atory or other pla		Date	20c. Locatio			
Om Page	17 05	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	The second secon	n State		EMTERY	ice)	10-20-	חות האדתו	MODE	MARYLAND	
alti	N TO SE	21. Signature of Sunetal Serv				Name and Addre	ess of Facility	10-20-	OO DALLI	MORE	MARILAND	
00 32	e e e	Xila la	01/	In ex	07	LLIAM C		COMMUNIT	Y FUNERA	AL HOM	E PA	
1000	0	232 Plint1. Enter the disease shock, or heart failure.	or complications that	caused the death.	Do not ente	r the mode of dyi	ing, such as ca	rdiac or raspiratory	arrast,		Approximate Interval Between	
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	ledical aminer	Immediate Cause (Finat disease or condition resulting in death)	a	ardi	ac	126	-hy	thine	2	IN		
		rooming in docum	6	Don to (or	ac a consequ	venee of)-	: 1	1. (	1			
per	n and ial-transit Examiner	LE LES TOURS OF THE	b	-350C	icut	non	WIT	N C	and	100		
9,000	ician and burial-transit al Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	1 T	as a consequ	renee-el)i	0	1/010	Lare.	00		
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9	Wed we	rasulting in death) Last	THE STATE OF	Sen	+= 0	D	0/4	t		J.		
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. 0	the at hed for hed for ysici	Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. D	23b. Did tobacco use contribute to the cause of de			
U. 1	ed by the detached							11	Yes 25 No	3 Pro	obably 4 Unknown	
(A) 50	d by F							24a. W	as an autopsy	24b. W	/ere autopsy findings	
Record he law require	page 2 should t							pe	rformed?	C	vailable prior to empletion of cause deeth2	
I Rec	has 36 2							4.5	Yes 2 No			
	certificate rector, pag	25. Was case referred to med	ical				Of Place of	f Death (Check onl		1	☐Yes 2□No	
of Vita		axaminer? 1 D-Yes 2 □ No	Hospital:	Inpatiant 2 E	R/Outpatient	3DYDOA Ot	her:	ing Home 5 Re		Other (Speci	(h/)	
	5 7	27. Manner of Death	28a. Date	1	28b. Time of	28c. Inju			ribe how injury occurred			
Vision	the fur the fur catio	Z C / NOCIONIN	estigation	in, bay raury	Injury Work?  M 1 Yes 2 No							
9	al Director: After ted in by the funer Certification:		ald not be armined 28e. Place build	ce of Injury - At hon ding, etc. (Specify)	ne, farm, stre	et, factory, office			(Street and Nu- Town, State)	mber or Rur	ral Route Number,	
Pal or	To de de											
To the Hospital	competely filled in Medical Cer	29a. Certifier  (Check only one)  2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.  (Check only one)										
4	Me / Me	29b. Signature and title of cert		nner stated.	^	29c. Licen	se number		29d. Date sig	ned (Month,	Day, Year)	
1 3	1%	D.	Thank	M	11.	0.C.	M.E		OCTOBER	14	2000	
1	4	30. Name and address of pers	on who completed cay	use of death (Item 2	23a) (Type, F				OCTOBER	тт,	2000	
M		1500	eph f	estan	-		Stree	t, Baltin	nore, Ma	rylan	d 21201	
	State	31. Date ijed (Month, Day, Ye		Registrar's Signatu								
	Registrar	OCT	182000	Barren	w 1	9 1						



Physician

1. Decedent's Nama (First, Middle, Last)

2. Date of Death

Day

3. Time of Death

6:50 P.M.

Birthplaca (Steta or Foraign Country)

South Carolina

10d. Inside City Limits 1 ☐ Yes 2 ☑ No

Physician /Medical	VIVE TOXES		Eugene	Bruns	on				OCTOBE	R 13, 20		6:50 P.
Examiner	4a Facility Nama (If not institution, g						4b. City, To	own, or L	ocation of Death	4c. County	of Death	
	VAMHCS FORT HOWAR  5. Social Sacurity Number 6.		ON 7. Age (In yrs.	last histoday	If Undar	1 Year	FORT If Undar		ARD 8. Date of Bird	BALTI		
Funeral Director	247-42-1424	ALIM OF E	81	Yrs.	Months	Days		Min.	(Month, De	y, Year) 5, 1919	Cou	placa (Steta or Fornitry) Ith Carol
	Usual Residence of Decedent	Λ	01						Jail. Z	0, 1919	500	icii caror
/lan	10a. State 10b. County		10c. Cit	y, Town or L	ocation		- 114			7116		10d. Inside City Lin
with the Meryland te or 2844 show to notified at	Maryland Anne A	runde1	G]	Len Bu	rnie							1 ☐ Yes 2 🔯
vith the Me or 28a-1 s	10e. Street and Number				10f. Zip	Code				10g. Citizen of V	Whet Cou	ntry?
	7722 Spencer Ro	oad				210	60			U.S	5.	
	11. Marital Status	12. Was Decad		,S. 13.	Was Deced	lent of	Hispanic Or	rigin? (Sp	ecify Yas or No Rican, etc.)		e - Amari ck, White	can Indian,
OZ OZ SPA	1 Naver Marriad 2 Married		2 □ No		1□Yas					Specify		
OY E. BRUNG 21215-0020 d within 72 hours etter sjene. The treatural, or the transfer and the treatural of the completed by Fu	3 Widowed 4 Divorced	Year or Da	tes: W.W.	II							**	hite
OY E. BR 121215-00; ed within 72 hours we then 'netural', we then 'netural', to the facilies completed by	15. Decedent's I (Specify only highast g			16a. Dece (Giva	dent's Usua kind of wor	l Occu rk done	ipation e during mos ed)	st of work	ring	16b. Kind of Bi	usiness/îr	ndustry
Y E 2121 swithin liens.	Elementary/Secondary (0-12)	College (1-	4or 5+)		uck D				30 . 4	Oil Co	mnan	.,
ROY nd 21 nd 21 si Hyglen other th vent, the	3rd 17. Father's Name (First, Middle, Las	at)		11	uck D	LIVE		er's Nam	a /First Middle	Maiden Surner		Y
yland yland build be fill Mental H arked oth effic even		David Mu	rraw B	rincon	Cr.		TO. MOU		acille I		,	
Should by and Ments marked amarked amarked amarked amarked amarked amarked amarked amarke events and the same amarked	19a. Informant's Name/Relationship		IIay D.	1		/Ctros	at and Numb			er, City or Town,	State 7	n Code)
Maryland d 2 should be file tht and Mental Hy T is marked table traumatic event		Daughter					Road					nd 21060
	20a. Method of Disposition	Jaagiioci	20b. F	leca of Disp	osition (Nen	na of			Date	20c. Location -		
Baltimore, semit. Peges 1 at Jepses 1 at J	1 ☐xBurial 2 ☐ Cramation 3		tate	emetery, cre			_		10/17/0			e, Maryla
Baltim, Peg Department Important: I any Injury o	4 Donation 5 Other (Spec		MO	• Stat			rass of Facili					
Baltimo permit. Peges Department of Important: It any Injury or police.	21. Signature of Furieral Servica Lice	911500	1	7						Funeral		
	Jesome 3	ramere	rusk					-	_	timore,	Md.	
	23a, Part 1. Entar the disaasa, or consnock, or heart failura. List only	mplications that ca ly one cause on aa	usad tha deat ch lina.	h. Do not en	ter the mod	e of dy	ing, such as	cardiac	or raspiratory a	rrest,		Approximata Interval Between Onset and Death
Physician / /Medical	Immediate Cause (Final											Oriset and Death
Examiner	disease or condition resulting in death)	a. METAS	TATIC S	MALL	CELL	LUN	G CAN	ER			1	7 months
			Due to (c	r as a conse	quenca of):							
nsit nin		b. END S	TAGE C			EAR	T FAII	LURE			i	
). Box 68760, death certificate be associed to attending physician and ed for use as the burish-trensit sician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events		Due to (c	r es a conse	quence of):							
Box 68760, ath certificate be ax thending physician for use as the burial stan/Medical Estan/Medical	Cause. Enter Underlying Ceuse (Disease or injury that initiated events	c		100							1	
). Box 687 steem certificate the attending physical for use as the sician/Medic	resulting in death) Last		Due to (o	r as a conse	quence of):							
Certification of the season of		d										
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P.O. net the de d by the detached Physic	Part II. Other significant conditions	contributing to dea	ith but not res	urang in me t	inderlying c	ausa g	iven in Part	1.		Yes 2 No	3 Pre	to the cause of dec bably 4½ Unkr
S, P as thet as thet be detailed by Pt									- '-	104 2010	3_11	Journal -425 Oliki
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should be should									perfo	rmed?	0	vailable prior to ompletion of cause deeth?
The lew require rate has been signed 2 should Completed									40	4 - AFI N		
f Vital Rysten: The Ingretor, pege director, pege	25. Wes case referred to medical						CC DI-		1 0	Λ	-	☐ Yes 2☐ No
Vita sicien. centifi lirector	examiner?	Hospital:	patient 2	ER/Outpatie	nt 3 DC	0	ther:		th (Check only o		or /Cano	(64)
Of N Physic rithis c aral dire	27. Manner of Death	28a. Date of		28b. Time of		8c. Inju	4 🗆 14	ursing m		denca 6 □Oth how injury occur		119)
dling th.	1 Netural 5 Pending 2 Accident investigati		, Dey Year)	Injury	м		ork? ⊒Yes 2.⊑	No				
Division of Vital Records, tall or attending Physician: The lew requiras the attendent.  In placetor: After this certificate hes been signed in by the funeral director, pege 2 should be a Certification: To Be Completed by	3 Suicida 6 Could not	be 28e. Placa o	of Injury - At he	ome, farm, st	reet, factory	, office	9		28f. Location (	Street and Numb	ber or Ru	rai Route Number,
Div Direction	4 Homicide	building	g, etc. (Specif	y)					City or To	wii, Siele)		
	29a. Cartifier 1 Certifying P	hysician: To the b	est of my kno	wiedge, deat	h occurred	at tha t	time, date ar	nd place,	end due to the	ceuse(s) end me	enner es	stated.
he Hospin 24 hours he Funer pletely fill edical	(Check only 2 Medical Exa	aminer: On the bas and manne	sis of axamina or steted.	tion and/or in	vastigation,	In my	opinion, de	ath occur	red at the time,	date and placa,	and due	to the cause(s)
Within To the Community of the Community	29b. Signature and title of certifier		ar M	0			nsa number			29d. Date signe	d (Month	Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

20c. Location - City or Town, State 17/00 Crowsnville, Maryland nce Funeral Home P.A. Baltimore, Md. 21225 Approximata Interval Between Onset and Death piratory arrest, 17 months 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ₺ Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 4a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No ck only one) ☐ Residence 6 ☐ Other (Specify) Describe how injury occurred ocation (Street end Number or Rural Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29d. Date signed (Month, Dey, Year) 29c. Licensa number October 13, 2000 041365 MD., 9600 NORTH POINT RD, FORT HOWARD, MD 21052

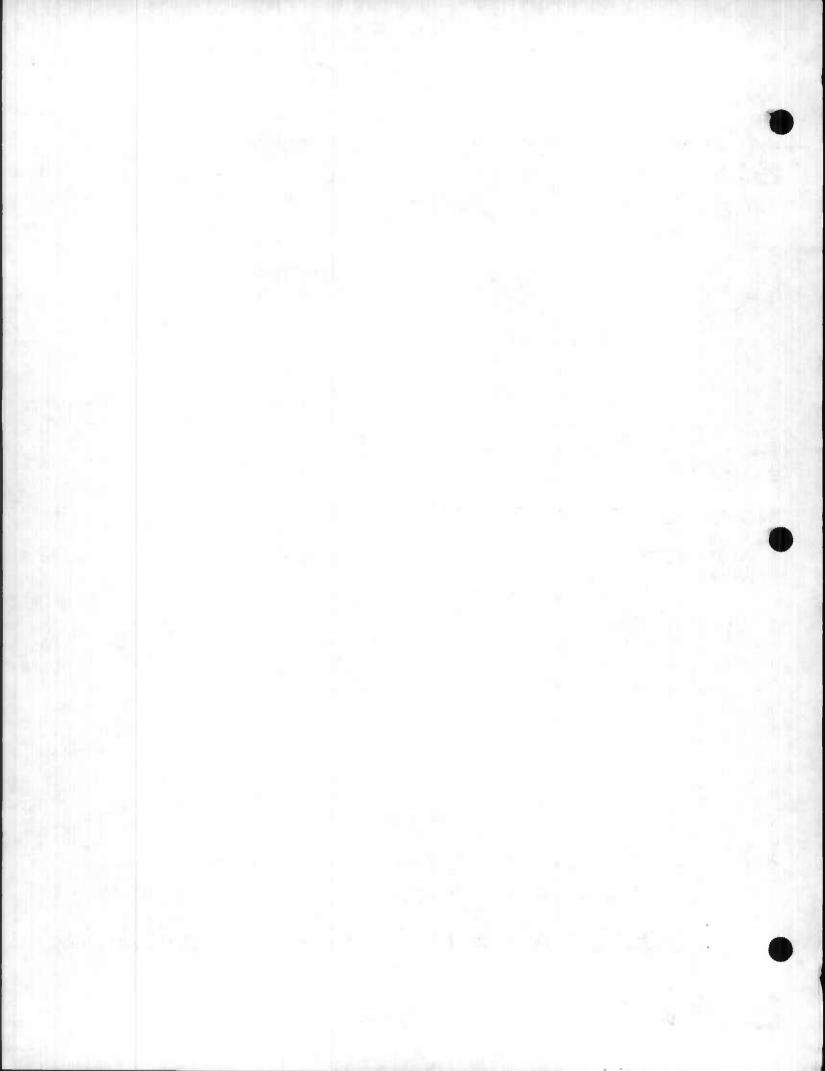
Registrar **DHMH 16 Rev 6/95** 

31. Date filed (Month, Dey, Year)

OCT 1 9 2000

GEORGE E. WICKS,

State



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3:05Pm DUTOBER 12 Aurelia Adel Brock 2000 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Anne Arundel North Arundel Hospital Glen Burnie If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer) Birthplace (Stete or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) Months Deys Hours Yrs. 220 14 5586 76 Virginia Oct. 6, 1924 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 2009 Norman Road 21061 U.S. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Never Married 2 ☐ Married ☐ Yes 2 No f Yes, Give 1 Yes 2 X No Specify Specify: White 3℃ Widowed 4 Divorced Year or Detes: 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 6th 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Jones Jeter Benson Mary 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 7756 Overhill Road Mollie Cool Daughter Glen Burnie, Maryland 21060 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from State 10/16/00 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery 22. Name end Address of Fecility 21. Signature of Funeral Service Licensee Gonce Funeral Home P.A. Baltimore, Md. 21225 4001 Ritchie Highway romerouselle or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Intervel Between Onset end Death RESPIRATORY Immediete Ceuse (Finet disease or condition resulting in death) OBSTRUCTUE PHLMONDRY DISERSE Due to (or es e consequence of): Pert II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy completion of ceuse of deeth? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28b Time of 28d. Describe how injury occurred 5 Pending investigation

**Physician** althaenear Examiner

**Physician** 

/Medical

Examiner

Directo

p

Completed

**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examples must be notified at

is 1 and 2 should be filed within 72 hours after at the and Mental Hygiene.

Pages hant of

= 8 Department of Important: If any Injury or

Baltimore, Maryland 21215-0020

the Maryland

with

death

Examin Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest edical 2 2 Physician/M 997

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Certification:

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page 2

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after deat Director:

24 hours Funeral

To the To the

b

Division

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

28e. Dete of Injury (Month, Day Yeer) 28c. Injury et Work? 1 Tyes 2 No

Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

 Location (Street end Number or Rurel Route Number, City or Town, Stete) Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated.

29b. Signeture and title of certifier

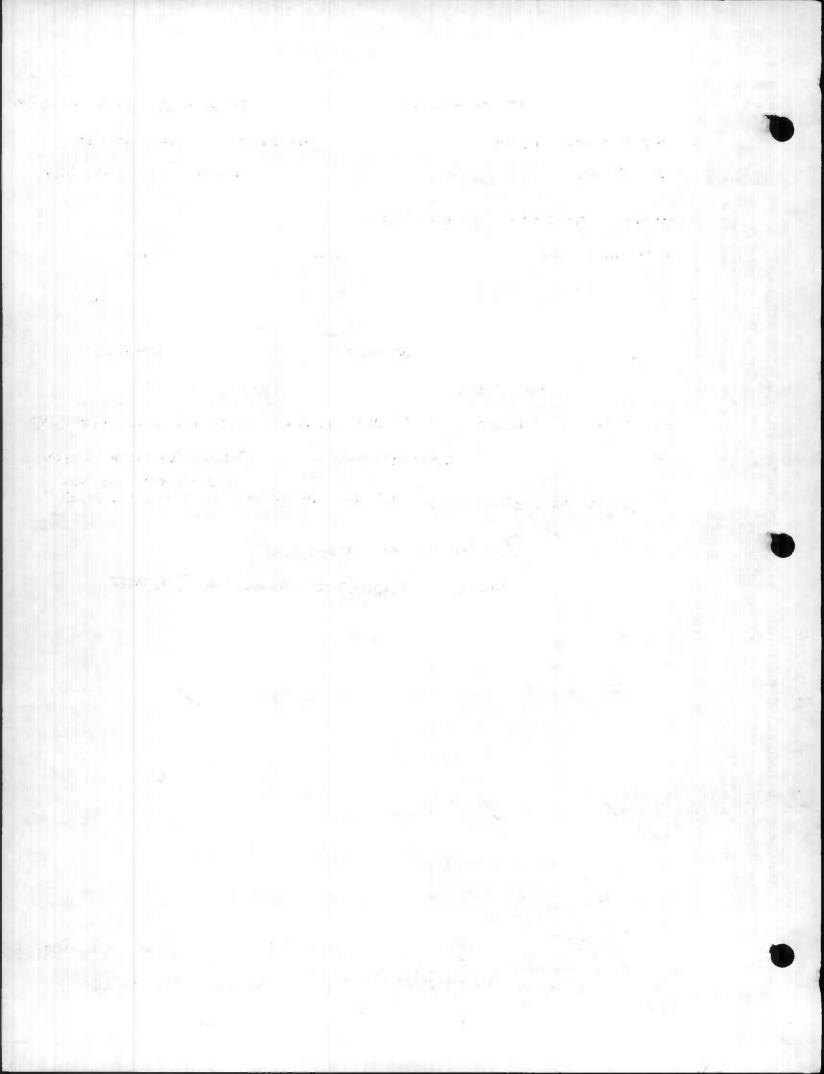
6 Could not be

29c. License number

29d. Date signed (Month. Dev. Year)

State Registrar

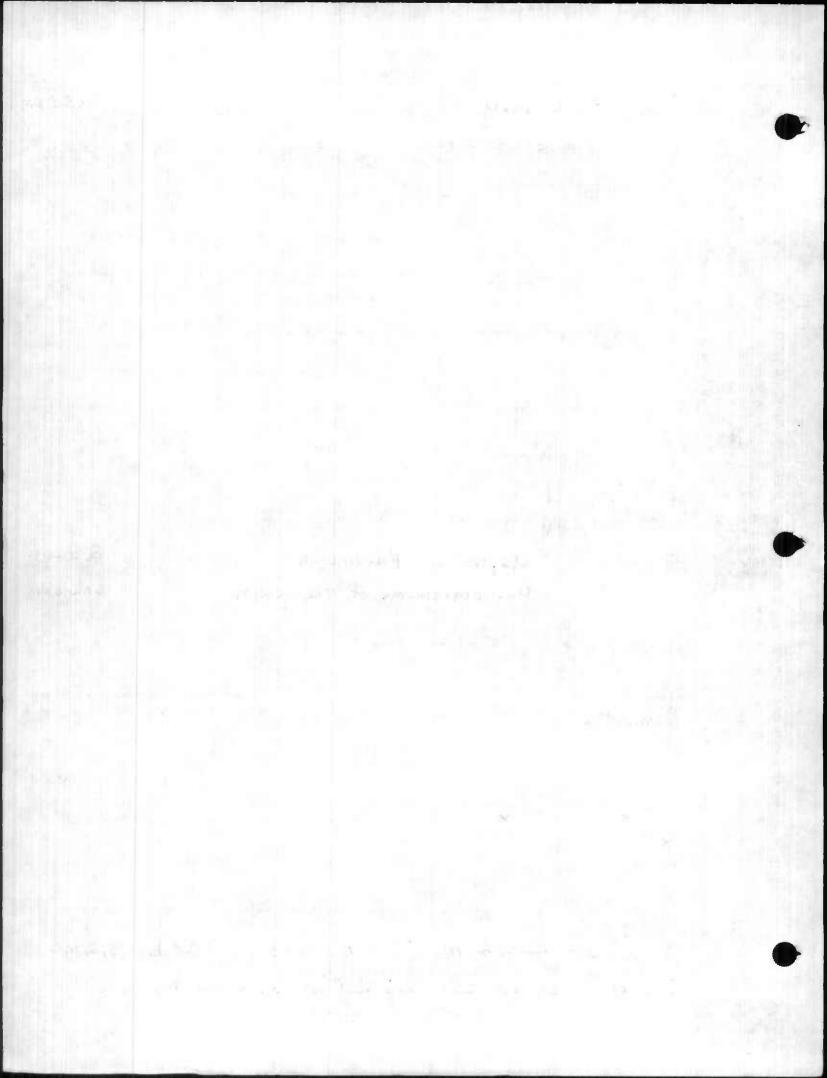
32. Registrer's



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O

	Decedent's Nama (First, Middla, Last)	Certificate of	2. Date of D	Reg. No.	3. Time of Death
Physician /Medical	John E. Chaney		OCTO		7:50 P
Examiner	4a Facility Name (II not institution, give street and number)  North Arunde) 1+05pi+0	c 1	4b. City, Town, or Location of Det	Anne A	cundal
Funeral Director	5. Social Security Number 213-05-9366 6. Sex 1 XM 2 F 7. Age (In yrs. In XM 2 F 93		If Undar 24 Hrs. 8. Date of B. (Month, I.		ce (State or Foreig
aryland ahow id.at	Usual Residence of Decedent  10a. State 10b. County 10c. City	y, Town or Location		10	d. Inside City Limit
with the Maryland a or 28a-1 show he notified at Director		adena 10f. Zip Code		10g. Citizen of What Country	1 ☐ Yas 2/☐/(\)
A with a state or a st	10a. Street and Number 1074 Johanna Court	21122		U.S.A.	y r
urs after death v at, or flems 23s Examiner mast by Funeral	11. Marital Stetus  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U, Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Hispanic Origin? (Specify Yes or tan, Mexicen, Puerto Rican, atc.)  Specify:	No- 14. Race - America Black, Whita, e	
ed within 72 ha ygiene. we then "naturn it, the Medical.] Completed	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondary (0-12)  College (1-4or 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of working d)	16b. Kind of Business/Indu	ustry
京工者を の	17. Father's Name (First, Middla, Last)	Maintenand	18. Mother's Neme (First, Midd		
To the To	Herbert Chaney  19a. Informant's Name/Rejetionship (Type, Print)	10b Mailing Address (Street	Mary (Unkn		Codel
0 7 2 2	Brenda Joyce Calk / daughter		Court, Pasadena		
	20e. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State	Place of Disposition (Name of emetery, crematory or other pla	Data Data	20c. Location - City or Tow	m, State
Separati. Page Separati II mportant: II my Injury or anse.	4 □ Donation 5 □ Other (Specify) Lou  21. Signature of Funeral Service Licensee	don Park Cemet 22. Name and Addre		O Baltimore, N	laryland
Physician /Medical Examiner  paragraphic Example: Example	adenocar	er as a consequence of):	nia the colon	(	a day
flicate be physicia as the bur edical	if any, leeding to immediate couse. Enter Underlying Cause (Disease or injury c.	r as a consequence of):			
at the death certified by the attending etached for use a Physician/Mc	Part II. Other algorificant conditions contributing to death but not resu	ulting in the underlying ceuse gi	ven in Part I. 23b. DI	d tobacco use contribute to	ths cause of de
es that the igned by ti be detach by Phy	Dementia		11	Yes 2No 3□ Prob	ably 4 Unkn
been s should leted			24a. W. pe	rformed? ava	re autopsy finding ilabla prior to apletion of cause eath?
cate h			1[	Yes 2 No 1	Yes 20 No
hysicien is certification of director of director To Be	25. Was case refarred to medicel axaminer? 1 ☐ Yes 2 No Hospital: 1 Impatient 2 ☐	ER/Outpatient 3 DOA	26. Place of Death (Check online) her: 4□ Nursing Home 5□ Re	y one) esidence 6 □Other (Specify	)
ith. : After this blunerel	27. Manner of Deeth  1 Manual 5 □ Pending 2 □ Accident investigation  28a. Date of Injury (Month, Day Year)	28b. Time of Injury Mo	ny at 28d. Describ	e how injury occurred	
To the Hospital or Attending Physicien: The lew within 24 hours effect death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	a □ Cutaida — 6 □ Could not be	ome, farm, street, fectory, office	281. Location City or 1	n (Street and Number or Rural Fown, State)	Route Number,
ne Hoepit n 24 hours he Funera pletely fille edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knot 2 Medical Examiner: On the basis of examinel and manner stated.	wledge, death occurred at the t tion and/or investigation, in my	ime, date and place, and due to the opinion, deeth occurred at the time	ne ceuse(s) and mannar as sta e, date and piace, and due to	ated. the ceuse(s)
within To the comple	29b. Signature end title of certifier		se number	29d. Date signed (Month, L	
	I Street Jacoba my		2483	October 15,	2000
/	30. Name and address of person who completed ceuse of death (Item	n 23a) (Type, Print)		1 000 2100	1
0	STUART JACOBS MD 200	Hospital Dr	ive. Glon Burn	ie, 11/1) 2/06	



Piease Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. AMENDED ITEM #11 PER INFORM. G789 1158 00 of Maryland / Department of Health and Mental Hygiene Reg. No. U Amend item 24a perPHYG788 10/19/00 EW Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death Month Year **Physician** 11:30Ar G. DOD Son 4a Facility Nama III not institution, giva street and number) 03 00 10 /Medical 4b. City. Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Veterans Home Charlotte Hall Saint Marys If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) **Funeral** Days Months 1₩ 2□ F Hours 83 Director 579-09-2768 January 7, 1917 Virginia Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland PrinceGeorges Bowie Yas 2□No Directo 288-1 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8 238 2308 Hillman Place 20716 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Hems 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, atc. 1 Nevar Married 2 Ma 1 ☑ Yas 2 ☐ No WW II 8 Maryland 21215-0020 Specity: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ℃Divorced natural. 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Management 12 permit. Pages 1 and 2 should be file.
Chepartment of Health and Mental Hy
Important: if Item 27 is marked othe
any injury or other treumsitic event,
phise. 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) William Mayo Dodson Virginia Bryant 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 20716 Glen Muir/ Son 2308 Hillman Place, Bowie, MD 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition October3 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Geo. Washington University 2000 Washington, D.C. 4 Donation 5 Other (Specify) Medical Center Addrass of Facility Signature Funeral Service Licenses Columbia Mortuary Services, Inc P.O. Box 58007 Washington, D.C. 20037 251 Pmm. Entar tha disease, or complications that caused tha death. Do not entar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on aach lina. Approximata Intarval Batween Onset end Death **Physician** CARCINOMA /Medical Immediata Causa (Final WEEKS disease or condition rasulting in death) Examine physicien and the buriel-transit Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Wara autopsy findings available prior to MELLITUS 24a. Was an autopsy performed? completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Vital 25. Was casa refarred to medical axaminer?

1 Yes 2 Ao 8 26. Place of Death (Check only ona) Other: Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA o 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? or Attending Patter death. 5 Pending 1 Tes 21 No invastigation 2 Accident Division 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1// Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and mannar stated. edical 29a. Certifier 29b. Signature and tale of continer 29c. License number 29d. Data signed (Month, Day, Year) 44436 & October 03 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASHVINKUMART PATE 613 6BPKFTON S& II WALDURFMED 20602 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State 16 20merra OCT 2000 Registrar

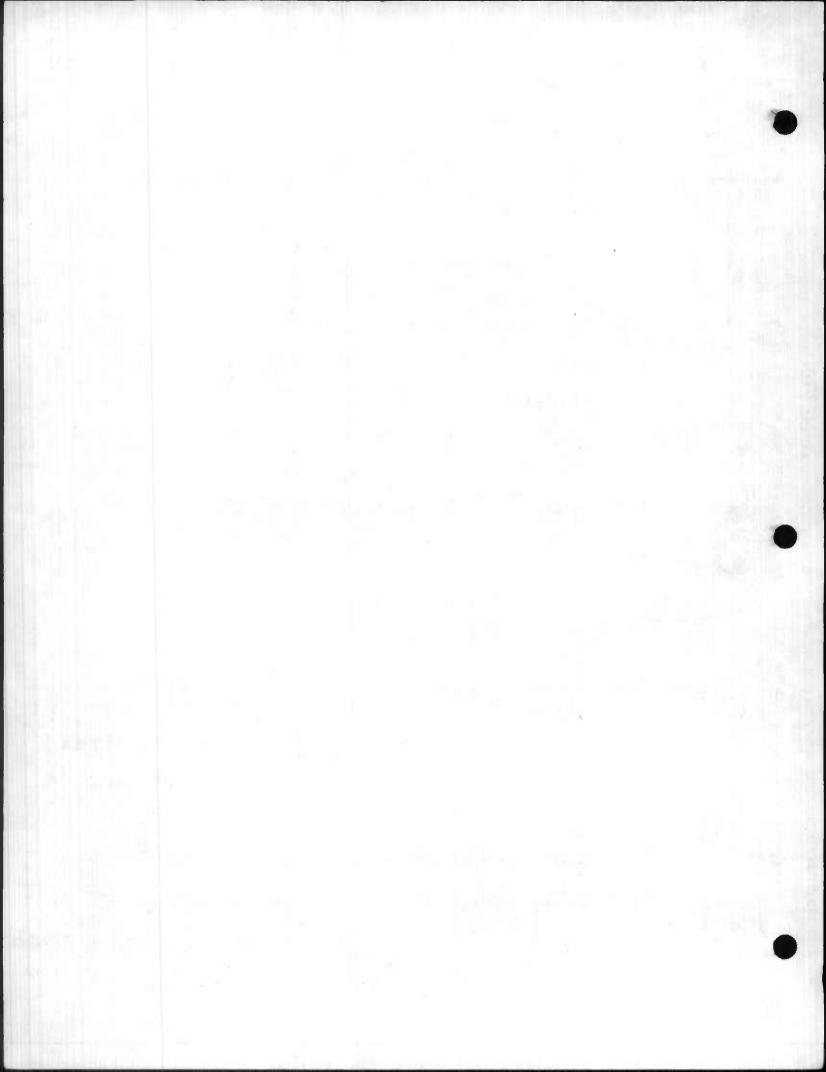
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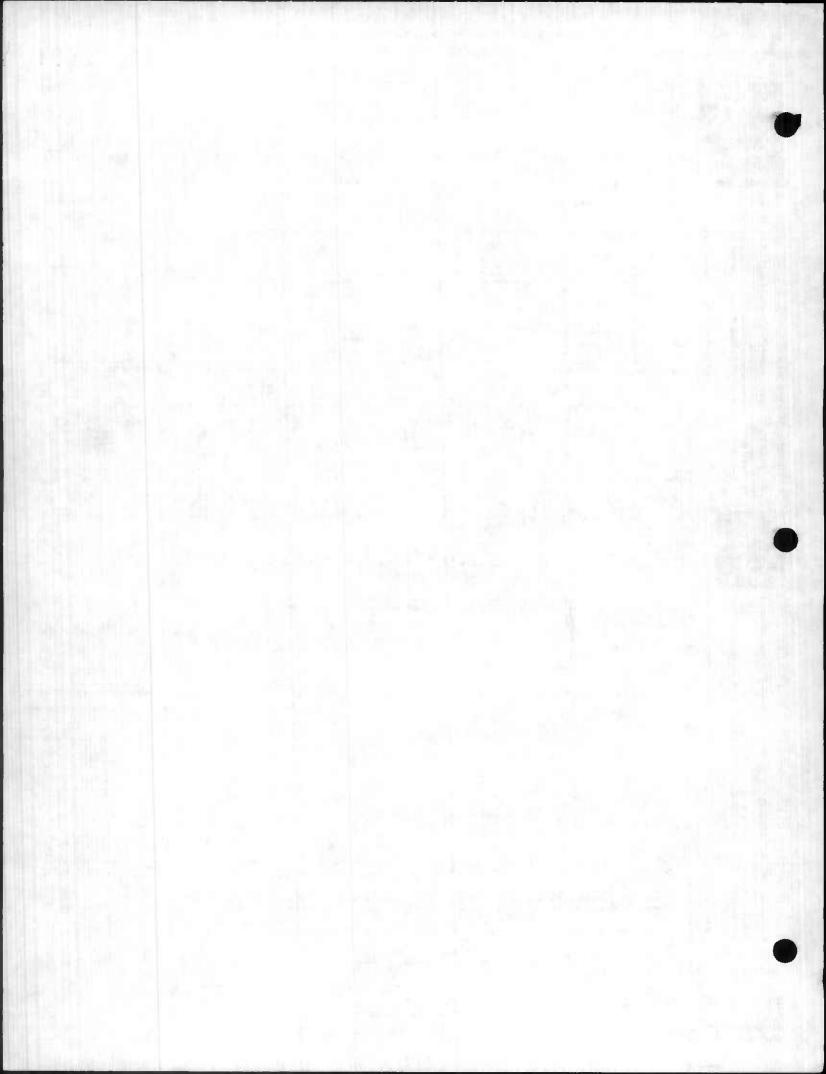
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Certificate of Death Reg. No.		
State of Maryland / Department of Health and Mental Hygiene	00	3299
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er	4a Facility Name (If not institut	ion, give	e street end nu	umber)				4	4b. City, To	wn, or Lo	cation of Dea	th 4c	. County	of Death	
	8910	) Sn	now Acr	es Dr	rive					urel				e Geo	orge's
	5. Sociel Security Number	6. S	ex DXM 2□ F	7. Age (II	n yrs. last b		If Unde Months	T 1 Year Days	If Under Hours	24 Hrs. Min.	8. Dete of B (Month, D	irth la <i>y, Year)</i>	)	9. Birthp	place (State or I
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ŀ	Usuel Residence of Decedent  10a, State 10b, Coun	ty		10	Oc. City, To	wn or Loc	cation							1	10d. Inside City
1	MARYLAND BAL	TIM	ORE			BALT	IMOR	E							1 Yes 2
ŀ	10e. Street and Number							p Code		m		10a. Cit	itizen of W	Vhet Cour	ntrv?
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	3 ☐ Widowed 4 ☐ Divorce	ed	If Yes, G Yeer or I	iVO 1	1972	1	I □ Yes	2KIXVo	Specify:				Specity:	WHI	LTE
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							Name e	nd Addre	ss of Fecilit	SIN	GLETON	FUNI	ERAL.	HOME	
l	21. Signature of Funeral Service	e Licen	isee	1		22.								HOPIE	E, P.A.,
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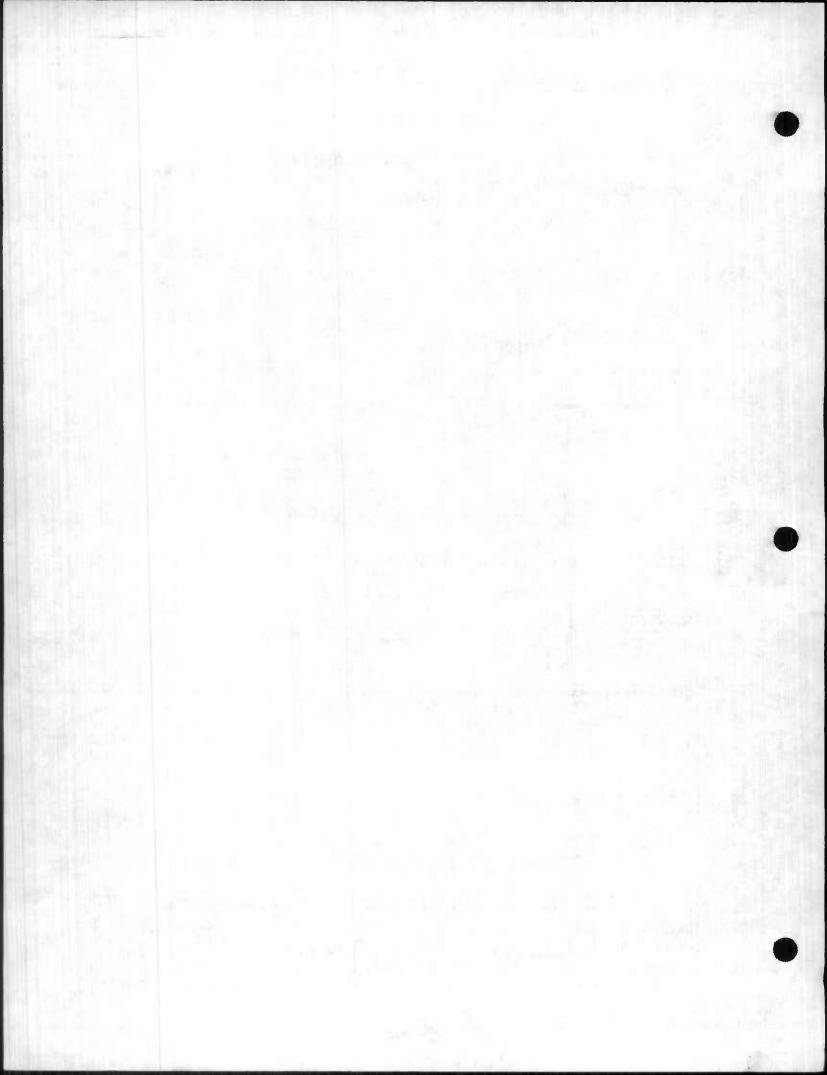
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State of Maryland / Department of Health and Mental Hygiene () 3 2 Q Q 2

			Certificate of D	eath	Rec	J. No.	22332
	1. Decedent'e Neme (First, Middle, Last)				2. Dete of Deeth		3. Time of Death
Physician	Evelyn L. Flei	ming			October	13. 2000	
/Medical Examiner	4e Fecility Neme (If not institution, give s		4b.	. City, Town, or Loc		4c. County of D	
64	101 Center Place,	Apt. 803		Dundalk		Balti	more
Funeral	5. Social Security Number 6. Sex	II ofte	Months Devs	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey, )	(ear) 9.	Birthplace (State or Foreign Country)
Director	034-10-3330	M 20XF 83	Yrs.		Sept. 14	, 1917 Ma	assachusetts
2 .	Usuet Residence of Decedent  10a. Stete 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
atho atho	Maryland Baltimo		Dundalk				1 ☐ Yes 2 ☑ No
or 28a-fit be notified Directo	10e. Street and Number	re	10f. Zlp Code		100	g. Citizen of What	
Coath with the Maryla erns 23e or 28e-f elvo remark be stofffied at meral Director	101 Center Place.	Apt. 803		222		u.s.	
ma 2 Limit		2. Wes Decedent Ever in U.S.	13. Wes Decedent of His If Yes, specify Cuben,	panic Origin? (Spe	city Yes or No-		American Indien,
020 our she st. or h Esamio	1 Never Merried 2 Married 3 X Widowed 4 Divorced	Armed Forces?  1 ☑ Yes 2 ☐ No 11 Yes, Give Yeer or Detes:		Specify:	rican, etc.)	Specify:	White, etc. White
i 21215-0 ed within 72 ho yglere, we then "netur it, the Medical.	15. Decedent's Educ (Specify only highest grade	ation 16e.	Decedent's Usuel Occupat (Give kind of work done du	iring most of workir	10	6b. Kind of Busine	ess/industry
To an and	Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)			0	
- 3 2 5 5 C O	12th Grade		Homemaker	18. Mother's Neme	Affirm Advanta Adv		n Home
Be ever	17. Father's Name (First, Middle, Last)  (First Name Unknown)	wn) Smith			,	e Unknow	101
Tyla merke marke		•		Anna			
and 2 st and 2 st setth and a 27 is n	Mrs. Jacqueline Ra	ttiner (dghtr) 9			ive, Bal	timore,	MD 21236
Pages 1 Pages 1 mt. if then ry or oth	20e. Method of Disposition 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Re	comete	Disposition (Name of ry, cremetory or other plece)			Oc. Location - City	
E Pa Partition of the P	4 □ Donation 5 □ Other (Specify)	Green	Mount Cremat	cory 11	0/18/00	Baltimor	e, Maryland
Sall emit spart ny in	21. Signeture of Funeral Service License		22. Nome and Address Schimunek	Funeral H	Home In	C.	
W 40284		uller	9705 Belai	r Rd., Be	altimore	, MD 21	236
8	23a. Pert1. Enter the disease, or complic shock, or heart failure. List only one	cations thet caused the deeth. Do e cause on each line.	not enter the mode of dying,	, such es cardiec o	r respiratory erres	st,	Approximete Intervel Between
Physician				,			Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Acute My	· Landinas c	Itanction			Minutes
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P.O. that the dead by the detached	Total agricult solidion con	Today to dout to the resulting it	This andonying seeds give				□ Probably 4 □ Unknown
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					24e. Wes en		4b. Were autopsy findings available prior to
s bee					portonii	901	completion of cause of death?
The law requirate has been a page 2 should Completed					1 ☐ Yes	2 10No	1 ☐ Yes 2 ☐ No
Vital Institute in Continue of Se Co	25. Wes case referred to medical			26. Plece of Deeth		~	
	examiner?	ospital:	tpatient 3 DOA Other	,.	ne 5 🕱 Residen		Specify)
Sing Physical distributions of the Tourist Idon: Tourist I	27. Menner of Death		Firme of 28c. Injury 9	et 2	28d. Describe how	v injury occurred	
Sior tendin leath. tor: Aff the fur	1 Neturel 5 ☐ Pending investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		es 2 No			
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #30 PER D.V.R. G788 10-20-00 WR. Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** 1 0 Month 2000 Sophie Marie Fryer 5: 23 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Masonic Homes Cockeysville Baltimore If Under 1 Year If Undar 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** (Month, Day, Year)
December 8,1902 1 M 2 F Yrs Baltimore, Maryland Director 218-46-3481 Usual Rasidence of Decadant permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend Department of Health and Mantal Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, in a Medical Example must be northed at once. 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Baltimore County 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Coda 21286 USA 1553 Putty Hill Avenue Funerai 12. Was Decedant Evar in U,S. Armad Forcas? 13. Was Decedant of Hispanic Origin? (Specity Yas or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, Whita, atc. 1 ☐ Yas 2 ☐ No il Yes, Giva X Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3√ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Housekeeping-Own Home Homemaker 17. Fathar'a Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be Josephine Christine Jilka Edward Joseph Rychtar 0 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1553 Putty Hill Avenue Baltimore, Maryland 21286 Nancy F. Green (daughter) 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 Cremation 3 Removal from State Parkwood Cemetery October 17,2000 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licensee 22. Name and Address of Facility
Lassahn Funeral Hone Inc 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiec or respiratory arrest, ahook, or heart failure. List only one cause on each line. 7401 Belair Road Baltimore, Maryland 21236 Approximate Intarval Batween Onset and Death Physician Cerebro Vasular Disease /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Dua to (or as a consequenca oi) Examiner The lew requires that the death certificate be axecuted attending physician and for use as the burial-transit Sequentially list conditions, if any, laading to immediata causa. Entar Undarfying Causa (Disaasa or Injury that Initiated evants rasuiting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequance of): ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Cerebal atrophy 1 Yes 2 No 3 Probably 4 Unknown signed t þ 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Colon Cancer has page 2 1 Yas 1 ☐ Yas 2 No certificate Hospital or Attending Physician: director, 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral Certification: 27. Mennar of Death 26a. Data ol Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Naturel 5 Panding after death. 1 ☐ Yas 2 ☐ No 2 Accident Investigation 6 Could not be datermined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, larm, streat, factory, office building, etc. (Specify) 4 Homicide 24 hours a

To the

State Registrar

**DHMH 16 Rev 6/95** 

within 2 To the

31. Data filad (Month, Day, Year)

30 Name and address of person ROBERT T. LIBERTO

29a. Certifier

(Check only one)

Medical

OCT 19 2000 32. Registrar's Signatura

who completed cause of death (Item 23a) (Type, Print) 3508 BANK SIREET BALTIMORE, MD 21224 oorks

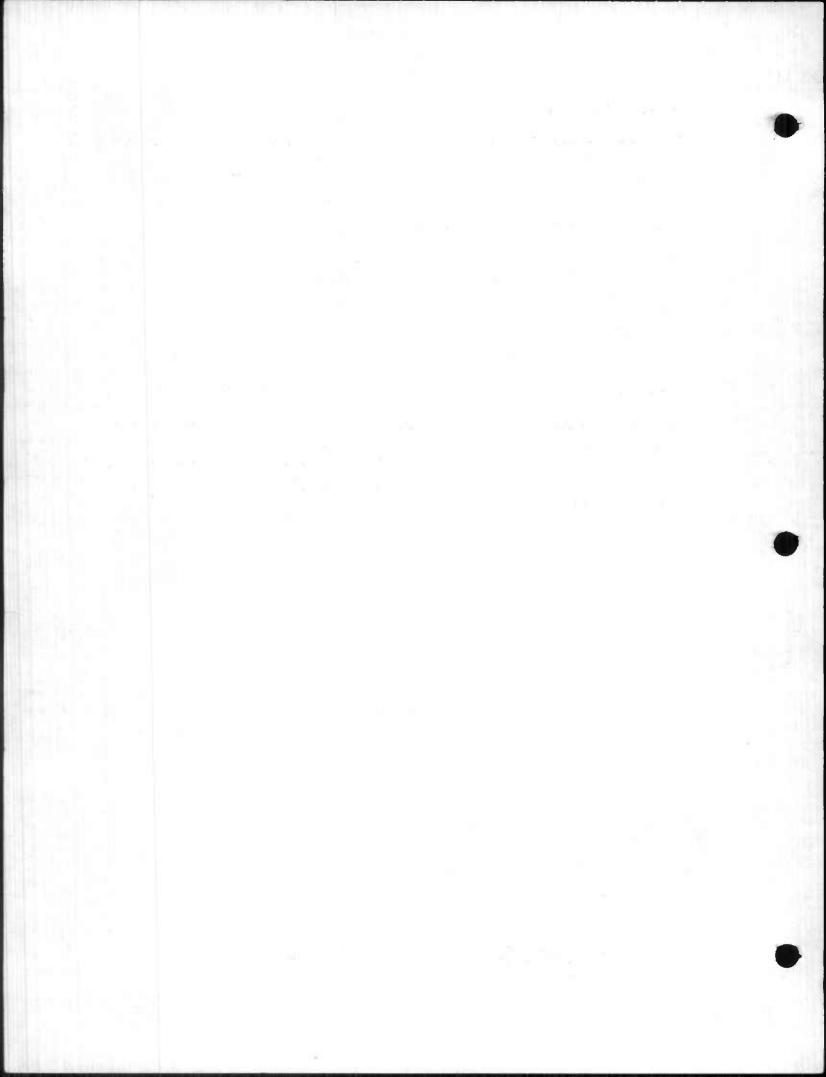
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(a) and manner stated.

29c. Licansa number

21464

29d. Date signed (Month, Day, Year) 10-16-00



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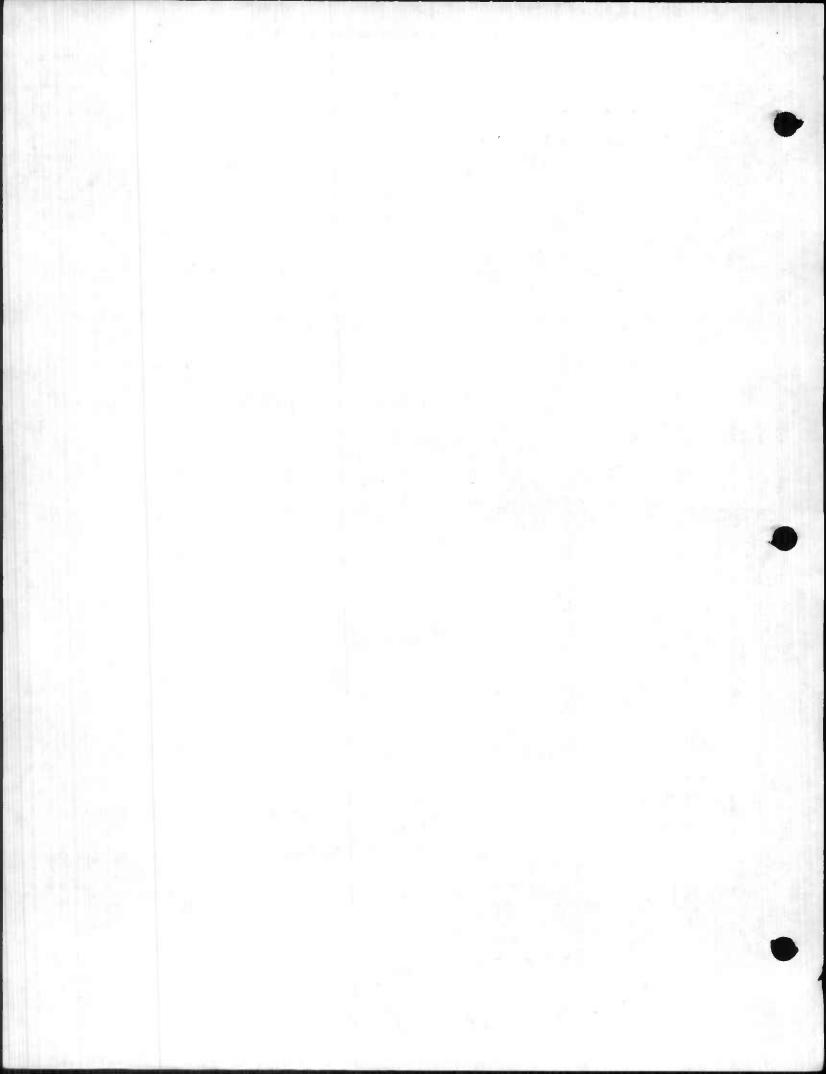
State of Maryland / Department of Health and Mental Hygiene

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Registrar

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00-5683-510 jhm Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. DONALD State of Maryland / Department of Health and Mental Hygiene 32995 GRAHM amend item 23a, 27, 28a, b, c, d, e, f per me G788 10/20/00 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Defe of Deeth 3. Tima of Death Day Month **Physician** DONALD GRAHAM 03:30 AM OCTOBER 06, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 20, 1959 MARYLAND GENERAL HOSPITAL 5. Social Security Number Unk 6. Sex Birthplace (State or Foreign Country) unk 7. Age (In yrs. last birthday) **Funeral** 180 M 2□ F Yrs. 41 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 25a-f show MD Baltimore 1 Yes 2 □ No Directo 10g. Citizan of What Country? 10a. Street and Number 10f. Zip Code ĕ 23a 21229 IISA 312 Martingale Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Unk If Yes, Give Year or Dates: 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status unk filed within 72 hours after 1 Never Married 2 Married 8 black Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: the Medical Exam py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk mit. Pages 1 and 2 should be filed within partment of Health and Mental Hyglens. ontant: If flem 27 is merked other than Elamantary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) unk unk 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C.M.E. 111 Penn Street Baltimore, MD 20b. Piace of Disposition (Name of cemetary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) In State 8 any Injury 21. Signeture of Fundral Serges Licenses Renald S. Wade, State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 many IT. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate fntarvat Batwaan Onset and Death **Physician** Immediate Cause (Final diseasa or condition rasulting in death) /Medical NARCOTIC AND COCAINE INTOXICATION Examiner Due to (or as a consequence of): Physician/Medical Examiner ng physician and es the buriel-trensit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequenca of): Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of): use P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Conknown by 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s 1 Pes 1 Oras 2 No or Attanding Physician: 25. Was case raferred to medical examiner? Be 26. Place of Death (Check only ona) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Data of Injury found: 10/6/00 28b. Time of 28d. Dascribe how injury occurred unknown 27. Manner of Death 28c. Injury at Work? edicai Certification: A 5 Pending investigation 1 Natural found? 1 Yes 2 No М death. 2 Accident after death 3:00 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2100 Madison 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 | Homicide To the Hospital o within 24 hours aft To the Funeral DI found: dwelling Baltimore, Maryland 1 Certifying Physician: To the best of my knowladga, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

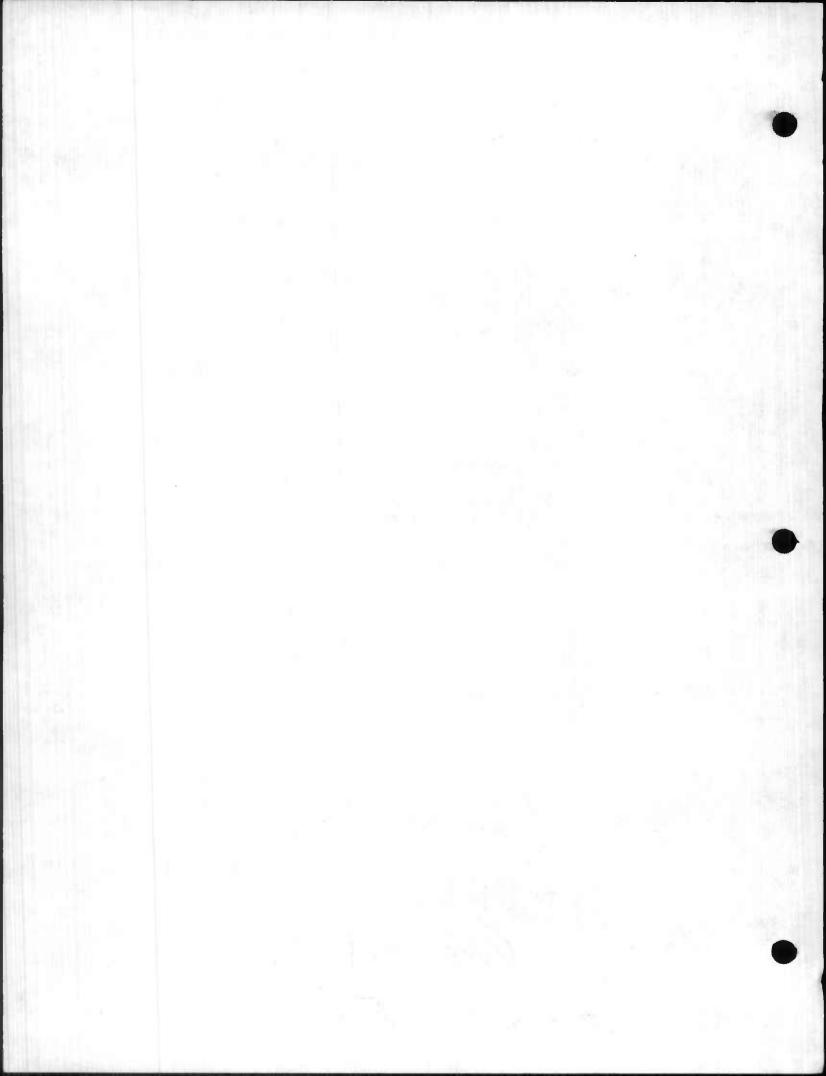
Wedical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and mennar stated. 29a. Cartifier (Check only one) 29b. Signature and title of certifie

Records, of Vital Division

29d. Data signed (Month, Day, Year) 29c. License number OCME OCTOBER 06, 2000 will, 30. Name and address of person who completed was of death (Item 23a) (Type, Print) RIFFE , M.A. 111 Penn Street, Baltimore, Maryland 21201 67-31. Date filed (Month, Day, Year) 32. Registrace Signature

State Registrar

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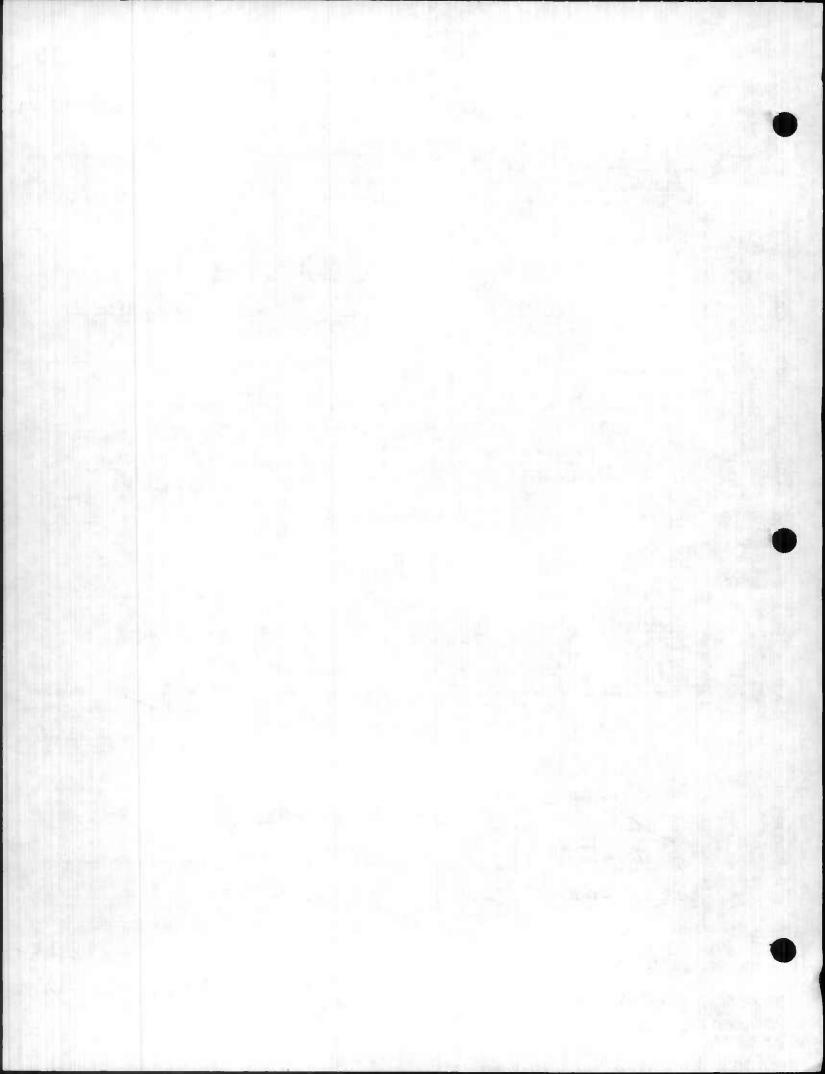


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= 5 # 5 E	Certification:	4 ☐ Homicide determined	28e. Plece of tnjury - At home, to building, etc. (Specify)	erm, street, tectory, office	28f. Location (Street end Number or F City or Town, Stete)	Hurei Houte Number,
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To the Hospital within 24 hours a To the Funeral completely filled	Me	29b. Signature and title of certifier	Λ	29c. License number	29dcPate aigned (Mor	nth, Dey, Year)
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2		30. Name and address of person who con	spieled cause of death (Item 23a)	(Type, Pript)		11
		1/a Hunder	enekul h	1938 greeneT.	ree Rd Pite	Juille 11) 21208
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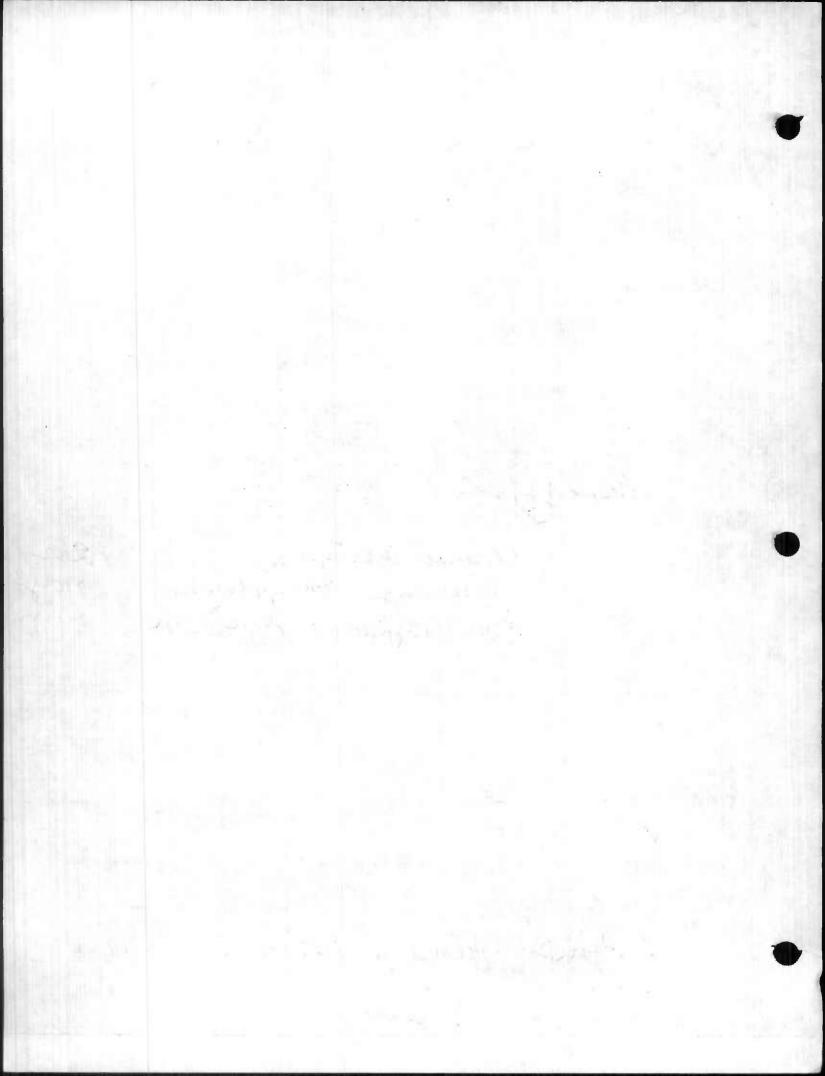
DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene () () 3 2 9 9 7

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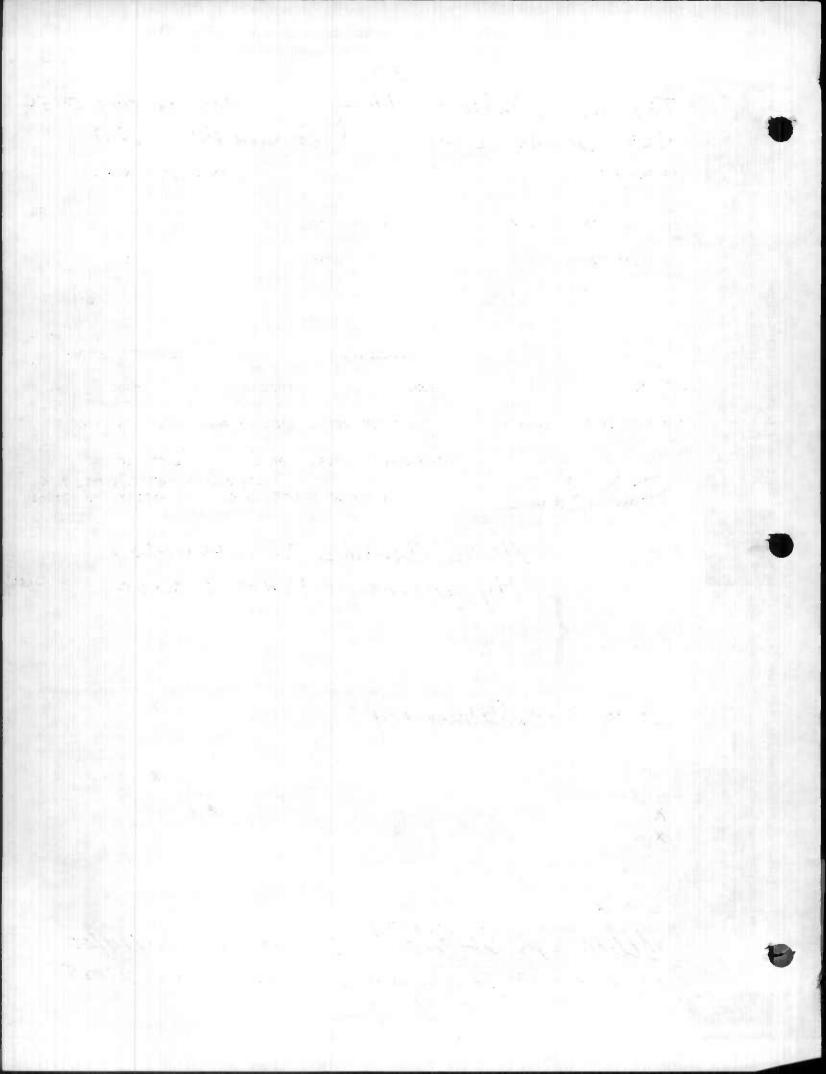


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State of Maryland / Department of Health and Mental Hygiene []

Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 085C **Physician** tone WAlter 2000 14 HOMAS /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Name (If not institution, give street and number Examiner Severna erby 88 If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 5. Social Security Number **Funeral** Months Deys Hours 1 X M 2 □ F Yrs. 48 MARYLAND JUNE 16,1952 **Director** 217-56-6872 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show 1 Yes 2 No Directo SEVERNA PARK MARYLAND ANNE ARUNDEL 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 488 DERBY COURT U.S.A. 14. Race - American Indian, hours after death Funeral 21146 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No 1973 -If Yes, Give Year or Detes: 1975 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 11. Maritai Status Black White, etc. 1 ☐ Never Married 2 ☑ Merried 1 ☐ Yes 2 A No Specify: Specify: Aq WHITE 3 ☐ Widowed 4 ☐ Divorced Completed pommir. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental hygiena. Important if item 27 is marked other than "natur my injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICIAN 12 CHEMICAL COMPANY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM HONG ADDIE MAY L. HOOD 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) MARGARET HONG (WIFE) 488 DERBY COURT, SEVERNA PARK, MARYLAND 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 10/18/2000 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) MEADOWRIDGE MEMORIAL PARK ELKRIDGE, MD. 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A,, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Penti. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner attending physician and for use as the bunal-transit law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) and Physician/Medical Due to (or as a consequence of) as t Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the a 1 Yee 2 No 3 Probably 4 Unknown ulmonaro à Division of Vital Records. 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an eutopsy Completed peen s has The 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To this funeral 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After Attending 1 Natural 5 Pending 1 Tes 2 No death. investigation 2 Accident a or Attend s after death i Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 2 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end manner stated. (Check only one) reputy 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 0 of person who completed cause of death (Item 23e) (Type, Print) 695 America 21025 JONES mo 2. Registrar's Signature

Registrar



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

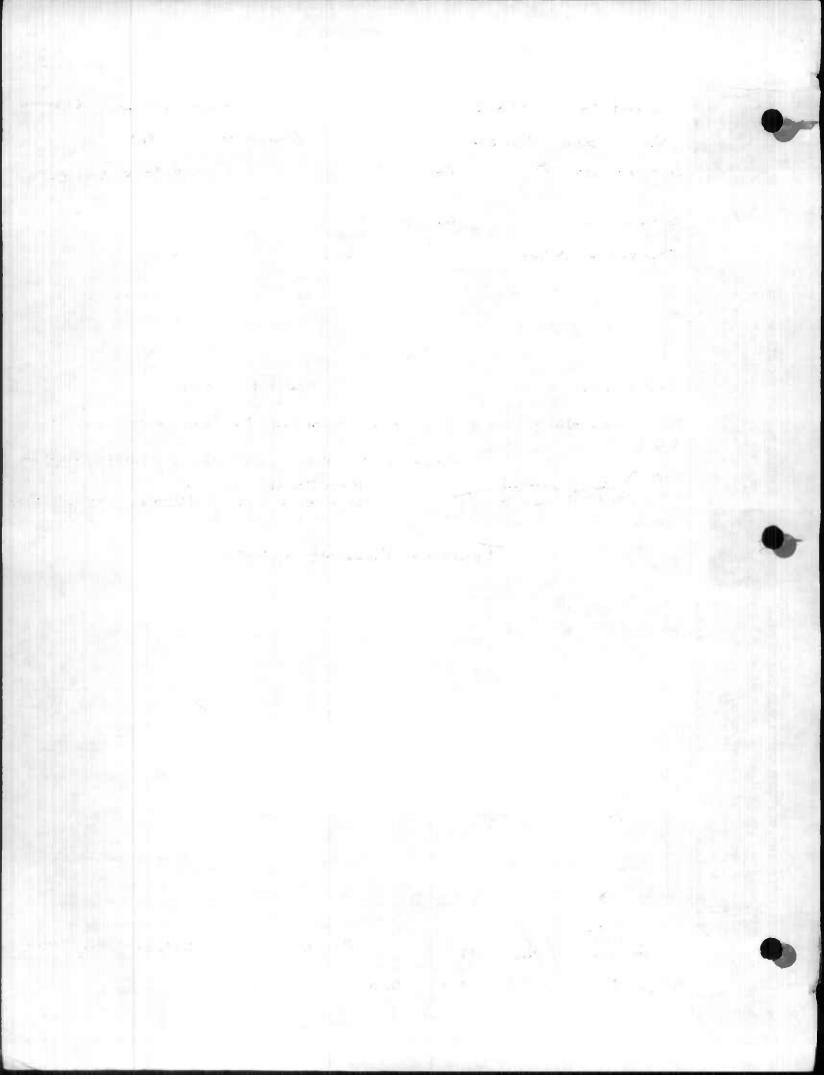
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Neme (First Middle Last) 2. Defe of Deeth 3. Time of Deeth Month Yee Physician 6:30 AM ITAYES OCTOBER CHANCES 2000 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALT, MORE CENTER VA MEDICAL if Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dev. Year) Birthplece (Stete or Foreign Country) **Funeral** Months Deys Hours Min 55 Yrs SEPTEMBER 14,1945 West Virginia 216-42-9459 Director Usuel Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-1 show notfied at 1X Yes 2 No Director Maryland n/a Baltimore 10e. Streef and Number 10f. Zip Code 10g. Citizen of Whet Country? with tam 27 is marked other than "natural", or flams 23s or other traumatic event, the Madical Examiner must be a 2625 Wilkens Avenue 21223 U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14 Race - American Indien 11. Meritei Status Bleck, White, etc. hours after 1 XYes 2 No If Yes, Give Yeer or Detes: 1 □ Never Merried 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Printing 12 6 Pressman 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be 12 should be finance and Mental His marked of Robert E. Lee Haves Janet Ileen Short 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 is n any Injury or other traun 220 West Arden Road, Baltimore, Maryland 21225 Judy Jones / sister 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 10/19/00 Glen Burnie, Maryland Glen Haven Mem. Park 21. Signature of Funerel Service Licensee 22. Name end Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Pucuonary I DIOPATITIC Examiner Due to (or es e consequence of): Examiner sician and burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) physician s the buria Box 68760 pe Physician/Medical Due to (or es a consequence of) esu. Po 23b. Did tobacco use contributa to the cause of death? ed by the a Pert II. Other elanificent conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. signed by to 3 Probably 4 Unknown 1 Yes 2 No Records, g 24b. Were eutopsy findings eveilable prior fo 24e. Wes en eutopsy performed? Completed peen completion of cause of deeth? has 22 No Division of Vital 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 Inpatient 2 ER/Outpetient 3 DOA this funeral 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Manner of Deeth Certification: 28h Time of 28c. Injury et Work? Aftar 1 Neturel
2 Accident 5 Pending or Attending after death. 1 ☐ Yes 2 ☐ No Investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours a 24 hours a Medical 29a. Certifier 1 🗮 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end menner es steted. npletaly (Check only one) 2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated. Within 2 To the Complet 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2000 3386 MD 104/ 30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print) 325 Kuns Greene Baltimo.

State Registrar

OCT 1 9 2000 DHMH 16 Rev 6/95

31. Dete filed (Month, Dey, Yeer)

32. Registrer's Signature



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** GYEWHAN HAN 2000 11:11 PM Oct 16 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a Joseph Richey Hospice Baltimore 9. Birthplace (Stata or Foraign Country) South Korea If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Dec 12 19 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Days Hours 15XM 20 F Yrs. Dec 1953 46 Director 219-39-6170 Usual Rasidence of Decedant 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County than "natural", or flams 23s or 28s, show the Medical Examiner must be notified at 1 Tyas 2 NO No Baltimore Maryland Baltimore Director 10n. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21227 South Korea 5 Red Heart Court Funeral Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - American Indian, Bleck, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forcas? 72 hours after 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yas 2 ☐ No If Yas, Giva 1 ☐ Yas 2 No Specify: Specify: Asian à 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry filed within Hygiene. Elamentary/Secondary (0-12) Collega (1-4or 5+) 4 Convenience Store Owner Convenience Store 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
important: If them 27 is manked other any injury or other traumetic event Be Unknown 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 5 Red Heart Court, Baltimore, Maryland 21227 Mi Jeong Han / wife 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 Cramation 3 Ramoval from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) 10/19/00 Baltimore, Maryland New Cathedral Cemetery 22. Nama and Addrass of Facility 21. Signature of Funaral Sarvice Licenses Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Squamous Cell Caremona Tonque /Medical Immediata Causa (Final disease or condition resulting in deeth) Examiner Examiner death certificata be axecuted Sequentially list conditions, if any, laading to immadiata ceusa. Entar Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last bunial-tran Dua to (or as a consequence of): the attending physician the doruge that burian Physician/Medical Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. detached 1 Yas 2 No 3 Probably 4 Unknown been signed by Vital Records, þ 8 The law requires 24b. Ware eutopsy tindings available prior to should Completed 24a. Was en autopsy completion of cause of deeth? this certificate has page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No Physician: director, Be 25. Was casa rafarred to medicel examiner? 26. Place of Death (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) HOSASCE 10 1 Yas 2 No o funeral 27. Mannac of Death 28b. Time of 28a. Data of Injury (Month, Day Year) 28d. Describe how Injury occurred 28c. Injury at Work? After t Medical Certification: Division Attending 1 2 Natural 5 Pending Invastigation s efter death. 1 ☐ Yas 2 ☐ No the 2 Accident 6 Could not be detarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 I Homicida ò To the Hospital within 24 hours e Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and dua to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and tipla of cogillo uni 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yourst Batto Ald 21201 Kobert YWIN MD

**DHMH 16 Rev 6/95** 

Registrar

31. Data filed (Month, Day, Year)

32. Registrar's Signatura

9 2000

